MEDICARE-MEDICAID ANTI-FRAUD ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

SECOND SESSION

ON

H.R. 15536

A BILL TO STRENGTHEN THE CAPABILITY OF THE GOVERNMENT TO DETECT, PROSECUTE, AND PUNISH FRAUDULENT ACTIVITIES UNDER THE MEDICARE AND MEDICAID PROGRAMS, AND FOR OTHER PURPOSES

H.R. 13347 and H.R. 14805

BILLS TO AMEND TITLE XIX OF THE SOCIAL SECURITY ACT TO PROVIDE FOR EFFECTIVE DETECTION AND PREVENTION OF FRAUD AND ABUSE IN CONNECTION WITH THE MEDICAL ASSISTANCE PROGRAM UNDER THAT TITLE

H.R. 6483

A BILL TO AMEND THE SOCIAL SECURITY ACT TO PROVIDE FOR THE ESTABLISHMENT OF AN INSPECTOR GENERAL FOR HEALTH ADMINISTRATION

H.R. 6623

A BILL TO AMEND TITLE XI OF THE SOCIAL SECURITY ACT TO PROVIDE FOR A SYSTEM OF REVIEWS, INSPECTIONS, AND AUDITS OF THE MEDICARE PROGRAM UNDER TITLE XVIII OF SUCH ACT, TO BE CONDUCTED BY A NEWLY ESTABLISHED INSPECTOR GENERAL FOR HEALTH ADMINISTRATION IN THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SEPTEMBER 22, 1976

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MEDICARE-MEDICAID ANTI-FRAUD ACT

WEDNESDAY, SEPTEMBER 22, 1976

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2261, Rayburn House Office Building, Hon. Paul G. Rogers, chairman, presiding.

Mr. ROGERS. The subcommittee will come to order, please.

The subcommittee today is holding public hearings on legislative proposals to deal with fraud and abuse in our medical care programs, most particularly medicaid.

These hearings come at a time when the subject of fraud and abuse in medicaid and medicare has been much in the public eye. This subcommittee has already included a number of provisions designed to deal with fraud and abuse in our clinical laboratories bill, H.R. 14319, currently pending before the House. I am hopeful we can achieve positive action on the bill, and see it become law before this session ends.

Recent hearings by the Subcommittee on Long Term Care of the Senate Select Committee on Aging have spotlighted the scandalous situation that occurs all too often when unscrupulous providers and lax program administration serve poor and aged patients—often with no other providers to turn to—under the umbrella of medicaid and medicare. These kinds of situations cannot be allowed to continue. They waste the taxpayers' money, they perpetuate poor medical care, they blacken the eye of social programs designed to help the aged and the needy, and they truly rob from the poor.

Recognizing the problem and finding adequate solutions, however, are two different things. Let me state my basic conviction about this: The problem lies not primarily with the law, but with a failure to administer these programs so that fraud is discovered and prosecuted and abuse is uncovered and stopped. The administration has not previously informed the Congress that they could not deal with fraud and abuse under the provisions of the current law and has not sought changes in the law if they are necessary. I regret that. I regret that instead we must deal with a set of proposals developed in the Senate in rapid response to the Moss hearings, which none of us will have adequate time to study sufficiently to be sure they will accomplish what we are trying to accomplish.

I would repeat what I said to my colleagues when I introduced, with Congressman Rostenkowski, the bill we are considering today.

The problem of fraud, and more particularly abuse in our publicly financed medical care programs, are complex. They involved inade-

quate numbers of able personnel administering the program at the State and Federal level; woefully inadequate data systems particularly in the medicaid program; unethical providers; a reimbursement system which too often encourages overuse; and a lack of alternate high-quality health facilities to serve the poor, particularly in certain areas of our major cities.

The bill we are reviewing today is clearly not designed to address these deep-rooted problems in our health care financing programs. Senator Talmadge acknowledged this himself in his statement when he introduced the bill. But it is designed to strengthen penalties for fraud, to provide the administration with a clear congressional directive to give priority to fraud and abuse activities, and to strengthen the Federal Government's access to information on providers.

It would be, in effect, a first step and I am interested to know from our witnesses today whether they believe it is a productive step.

Now, I do want to say that the Committee on Ways and Means and the distinguished chairman of that Subcommittee on Health have been most cooperative. We have been in constant contact on this, and we have a staff member of that committee sitting with us today whom we welcome.

I also have received a letter from the Honorable L. H. Fountain who is Chairman of an Intergovernmental and Human Resources Subcommittee which is from the Committee on Government Operations. Without objection, we will put his letter in the record because Congressman Fountain has done yeoman service in trying to set up the mechanism where we can keep on top of improper conditions in the administration of these programs. I just want to read portions of his letter.

As the primary sponsor of H.R. 15390, I want to take this opportunity to comment on Section 3 of the Talmadge bill, which would establish a separate central fraud and abuse unit whose jurisdiction would be limited to medicare, medicaid and certain other health programs.

I do not believe the separate unit called for under Section 3 would be necessary if the provisions of H.R. 15390 are enacted into law. The Inspector General, in my judgment, could and would do an effective job of carrying out the medicare-medicaid anti-fraud and abuse activities contemplated under Section 3.

I have been advised informally that consideration may be given to substituting the language of H.R. 15390, with two minor modifications, for Section 3 of the Talmadge bill. The proposed modifications, as I understand them would:

(1) provide that the Inspector General shall establish within his office an appropriate and adequate staff with specific responsibility for devoting their full time and attention to anti-fraud and anti-abuse activities relating to medicare, medicaid and certain other health programs; and

(2) provide that the Inspector General shall report particularly serious or flagrant problems, abuses or deficiencies immediately to the Secretary and within seven days thereafter to appropriate congressional committees, rather than making immediate reports to both the Secretary and the committees.

In my judgment, the proposed modifications would not hamper the effectiveness of the Office of Inspector General and I would see no reason to object to them.

I am enclosing copies of House Report 94–1573, which contains further details concerning H.R. 15390."

[Chairman Fountain's letter follows:]

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
INTERGOVERNMENTAL RELATIONS AND HUMAN RESOURCES
SUBCOMMITTEE, COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, D.C., September 22, 1976.

Hon. PAUL G. ROGERS,
Chairman, Health and the Environment Subcommittee,
2415 Rayburn House Office Building,
Washington, D.C.

DEAR MR. CHAIRMAN: As you know, the Committee on Government Operations has unanimously approved H.R. 15390, a bill to establish an Office of Inspector General for the Department of Health, Education, and Welfare. The bill is based upon information obtained during more than 18 months of study and investigation by the Intergovernmental Relations and Human Resources Subcommittee, which included extensive hearings and the preparation of a comprehensive oversight report.

As the primary sponsor of H.R. 15390, I want to take this opportunity to comment on Section 3 of the Talmadge bill, which would establish a separate central fraud and abuse unit whose jurisdiction would be limited to medicare, medicaid and certain other health programs.

I know that Section 3 results from deep concern on the part of Senator Talmadge and other Senators about massive and pervasive fraud and abuse in the medicaid and medicare programs, and I am totally sympathetic to their objectives. However, I have serious reservations about possible weaknesses in the unit to be created under Section 3, and the effect it would have on the proposed Office of Inspector General.

By establishing a separate fraud and abuse unit for medicare and medicaid only, outside the Office of Inspector General, Section 3 would further fragment HEW's already chaotic organizational structure, and would almost inevitably hamper efforts to bring about needed simplification and consolidation.

Moreover, Section 3 leaves many unanswered questions concerning the exact nature of the unit to be established and how it would operate. For example:

It is not clear who would head the new unit, and what his or her qualifications would be.

There are now specific requirements for reports or information to be provided to the Secretary or the Congress.

It is not clear where the new unit would be located organizationally, nor does there appear to be any prohibition against its being under the control of officials responsible for the programs being investigated.

There is no provision for subpoena authority or for mandatory access to information in the possession of HEW.

I do not believe the separate unit called for under Section 3 would be necessary if the provisions of H.R. 15390 are enacted into law. The Inspector General, in my judgment, could and would do an effective job of carrying out the medicare-medicaid anti-fraud and abuse activities contemplated under Section 3.

I have been advised informally that consideration may be given to substituting the language of H.R. 15390, with two minor modifications, for Section 3 of the Talmadge bill. The proposed modifications, as I understand them would:

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(2) provide that the Inspector General shall report particularly serious or flagrant problems, abuses or deficiencies immediately to the Secretary and within seven days thereafter to appropriate congressional committees, rather than making immediate reports to both the Secretary and the committees.

In my judgment, the proposed modifications would not hamper the effectiveness of the Office of Inspector General and I would see no reason to object to them.

I am enclosing copies of House Report 94–1573, which contains further details concerning H.R. 15390.

Best wishes.

Sincerely,

L. H. Fountain, *Chairman.*

Mr. Rogers. In conclusion, I think by cooperation between the Committee on Government Operation, the Ways and Means Committee. and this committee, we can get some action this time.

Mr. Scheuer will also make a statement at this time.

Mr. Scheuer. Thank you, Mr. Chairman, I am very glad that the chairman of the subcommittee has taken the time and made the effort in the midst of our very hectic prerecess schedule to hold a hearing on this very urgent problem.

As a member of the Oversight and Investigations Subcommittee of Interstate and Foreign Commerce I cochaired a hearing on medicaid fraud and abuse in New York City last February. At that hearing the theme that resounded again and again was the proven cost effectiveness of fraud and abuse prevention resources, including foremost financial assistance, improved prosecution capabilities on the local, State and Federal level, better communications among the States on refining the "state of the art" of fraud and abuse detection and prevention and more cooperation between State medicaid offices and local jurisdictions as well as between States and HEW. There was a general consensus among the witnesses that HEW had failed in its job to really help the States improve their fraud and abuse detection and prevention capabilities. Medicaid officials find themselves utterly frustrated in attempting to get a handle on fraud and abuse a problem which in New York City alone amounts to 20 percent of a $2-billion medicaid bill.

Overutilization, irregular billings, ping-ponging, family ganging, kickbacks, and related ripoffs have come to characterize the medicaid program. One has only to read the daily newspaper to be reminded of the latest scandal and the outrageous waste of taxpayers' money. The problems of fraud and abuse are well documented and the time to take appropriate action is right now.

Last July, together with Congressmen Moss and Maguire I introduced the Medical Assistance Accuntability Act of 1976 (H.R. 14805). This legislation was a direct response to dealing with some of the problems in the medicaid program which we heard so much about at the February hearing. Among other things H.R. 14805 provides for a Special Auditor General for Medicaid Fraud and Abuse within HEW, 90 percent Federal funding for State medicaid fraud and abuse detection and prevention activities, incentives for increasing computer retrieval capabilities to detect medicaid fraud and abuse and setting up an improved and more effective communication and reporting system on medicaid fraud and abuse detection and prevention activities on both the State and Federal level.

As you can well see H.R. 14805 is similar in many respects to the other pieces of legislation being considered today. Above all we realize the urgent need to get a handle on fraud and abuse in Federal programs which are costing the Government over $1 billion each year. Certainly this is an essential first step before we progress down the road toward a national health program.

I welcome the witnesses here today who have come to give us their expertise, evaluate our various proposals and hopefully give us their

ideas on how we can build, on both the Federal and State level a fraud and abuse detection program that will be effective, relatively easy to administer, and above all, "doable."

Mr. ROGERS. There being no objection, we will now recess for approximately 10 minutes in order to answer the call of the House.

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order, please. Dr. Carter has a statement he would like to make.

Mr. CARTER. Mr. Chairman, I share the concern of various members of the committees of Congress over the recent reports of fraud and abuse of medicare and medicaid. Just in the areas of clinical laboratories alone, it has been estimated that at least $45 million of the $213 million in medicare and medicaid payments for clinical laboratories is either for fraudulent or unnecessary services. Regrettably, when the entire scope of service provided under medicare and medicaid in considered, the extent of fraud is even greater.

I appreciate the opportunity, Mr. Chairman, to review these bills before us and to discuss how we should proceed in order to strengthen the capability of the Government to prevent, detect, and prosecute the fraudulent activities which are going on throughout our country. I look forward to hearing from the witnesses today.

Mr. ROGERS. Thank you, Dr. Carter. Mr. Preyer did you have any comment?

Mr. PREYER. I have no comments, Mr. Chairman. I am delighted you are proceeding with this hearing.

Mr. ROGERS. Mr. Scheuer, do you have further comments.

Mr. SCHEUER. Let me add, I think it is particularly essential for this committee get into the problem of medicaid fraud. It is this committee's responsibility, along with the Health Subcommittee of the Ways and Means Committee, to make some major initiatives in the direction of moving toward a national health program. It is abundantly clear that we have not yet begun to get a handle on some of the individual elements of a national health program that we have already put in place—namely medical and medicare. It would be the height of irresponsbility for us to move further ahead until we feel we have some semblance of control over these existing programs.

Mr. ROGERS. Thank you very much. Without objection, the text of H.R. 15536, H.R. 13347, H.R. 14805, H.R. 6483, and H.R. 6623 will be placed in the record at this point.

[Testimony resumes on p. 56.]

[The bills referred to follow:]

94TH CONGRESS
2D SESSION

H. R. 15536

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 13, 1976

Mr. ROGERS (for himself and Mr. ROSTENKOWSKI) introduced the following bill; which was referred jointly to the Committees on Ways and Means and Interstate and Foreign Commerce

A BILL

To strengthen the capability of the Government to detect, prosecute, and punish fraudulent activities under the medicare and medicaid programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Medicare-Medicaid Anti-Fraud Act".

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Sec. 3. Prohibition against assignment by physicians and others of claims for services.
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Sec. 5. Penalty for defrauding medicare and medicaid programs.
Sec. 6. Amendments related to professional standards review organizations.

OFFICE OF CENTRAL FRAUD AND ABUSE CONTROL

SEC. 2. (a) Section 702 of the Social Security Act is amended—

(1) by inserting "(a)" immediately after "SEC. 702", and

(2) by adding at the end thereof the following new subsection:

"(b) There shall be established, within the Department of Health, Education, and Welfare, an Office of Central Fraud and Abuse Control. Such Office shall have the overall responsibility for (1) directing, coordinating, monitoring, and establishing policies with respect to the undertaking of activities which are designed to deal with fraud and abuse, at all Federal organizational levels of the various programs established by or pursuant to titles V, XVIII, and XIX, and the renal disease program established by section 226 (ii) initiating and conducting investigations with respect to alleged, actual, or potential fraud or abuse in any of such programs, and (iii) assisting State agencies, at their request, in the establishment and operation of State anti-fraud and abuse activities. Such Office shall also provide all appropriate investigative support and assistance (including temporary delegation and assignment of personnel) to United States attorneys and State law en-

forcement authorities, upon their request, in the development of fraud cases arising out of any of such programs.".

PROHIBITION AGAINST ASSIGNMENT BY PHYSICIANS AND OTHERS OF CLAIMS FOR SERVICE

SEC. 3. (a) Section 1842(b)(5) of the Social Security Act is amended by adding at the end thereof the following new sentence: "Any payment for a service, which under the provisions of the preceding sentence may be made directly to the physician or other person furnishing such service, may not be made to a person claiming such payment under an assignment, including a power of attorney (other than an assignment to a governmental entity or establishment, or an assignment established by or pursuant to the order of a court of competent jurisdiction from such physician or other person furnishing such service); but nothing in this paragraph shall be construed to preclude an agent of the physician or other person furnishing the service, from receiving any such payment, if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of any such payment is unrelated (directly or indirectly) to the amount of the billings or payments (or the aggregate of similar billings or payments), and is not dependent upon the actual collec-

lection of any such payment (or the aggregate of such payments).".

(b) Section 1815 of such Act is amended by adding at the end thereof the following new subsection:

"(c) Any payment for a service, which under the provisions of this title, may be made directly to a provider of service furnishing such service, may not be made to a person claiming such payment under an assignment, including a power of attorney (other than an assignment to a governmental entity or establishment, or an assignment established by or pursuant to the order of a court of competent jurisdiction from the provider of service furnishing such service); but nothing in this subsection shall be construed to preclude any agent, of the provider of service furnishing such service, from receiving any such payment, if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of any such payment is unrelated (directly or indirectly) to the amount of the billing or payment (or the aggregate of similar billings or payments), and is not dependent upon the actual collection of any such payment (or the aggregate of such payments).".

(c) Section 1902(a)(32) of such Act is amended—

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(1) by inserting "(A)" immediately after "provide that",

(2) by redesignating clauses (A) and (B) as clauses (i) and (ii), respectively, and

(3) by adding immediately before the semicolon at the end thereof the following: ", and (B) any payment for a service, which may be made directly to the physician or other person furnishing such service, may not be made to a person claiming such payment under an assignment, including a power of attorney (other than an assignment to a governmental entity or establishment, or an assignment established by or pursuant to the order of a court of competent jurisdiction from such physician or other person furnishing such service); but nothing in this paragraph shall be construed to preclude any agent, of the physician or other person furnishing the service, from receiving any such payment, if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing and/or collection of any such payment is unrelated (directly or indirectly) to the amount of the payment (or the aggregate of similar billings and/or payments)

and is not dependent upon the actual collection of any such payment (or the aggregate of such payments).".

(d) The amendments made by subsections (a) and (b) of this section shall take effect on the first day of the first calendar month which begins not less than sixty days after the date of enactment of this Act, and the amendments made by subsection (c) of this section shall take effect on July 1, 1977.

DISCLOSURE OF OWNERSHIP AND FINANCIAL INFORMATION

SEC. 4. (a) Part A of title XI of the Social Security Act is amended by adding at the end thereof the following new section:

"DISCLOSURE OF OWNERSHIP AND FINANCIAL INFORMATION

"SEC. 1132. (a) (1) The Secretary shall by regulations (or by contract provision) provide that any entity (other than a public agency) which is—

"(A) a provider or supplier of items or services (including any 'shared health facility', as defined in section 1132, or any practitioner or supplier affiliated with such a facility), which furnishes, or which arranges for the furnishing of, items or services with respect to which payment is claimed under title XVIII, under any program established pursuant to title V, or under a State plan approved under title XIX;

"(B) (i) a party to an agreement with the Secretary entered into pursuant to section 1816 or 1842(a), or (ii) a party to an agreement, with a State agency administering or supervising the administration of a State plan approved under title XIX, under which such party serves as a fiscal agent for the State in the operation of such plan;

shall promptly comply with any request, made by the Secretary or the Comptroller General of the United States for any or all of the following:

"(C) full and complete information as to the identity (i) of persons having (directly or indirectly) ownership interests in such entity and the nature and extent thereof or who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by such entity or any of the property or assets thereof, (ii) in case such entity is organized as a corporation, of each officer and director of the corporation, and (iii) in case such entity is organized as a partnership, of each partner;

"(D) full and complete information as to any business dealings between such entity and persons referred to in clause (C), and

"(E) a consolidated certified costs report with respect to its costs and charges, including costs and

charges of related organizations (as that term is employed for purposes of title XVIII);

except that, in the administration of this paragraph, no such request shall be made of an entity described in paragraph (A) if such entity does not furnish a significant volume (as defined by regulations of the Secretary) of the items or services referred to in such paragraph.

"(2) (A) If at the close of the sixty-day period which begins on the date a request (as described in paragraph (1)) is made of an entity described in paragraph (1) (A), or (B), such request has not been fully complied with, then—

"(i) in case such entity is an entity described in paragraph (1) (A), the Secretary may notify such entity that no payment will be made to such entity under title XVIII, and no Federal funds shall be available with respect to any expenditures made under or pursuant to title V or XIX (or a program or plan approved thereunder), for or on account of any services furnished by such entity on or after the first calendar month which begins not less than thirty days after the date such notice is sent,

"(ii) in case such entity is an entity described in paragraph (1) (B) (i), the Secretary may notify such entity that any agreement between such entity and the

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Secretary entered into pursuant to section 1816 or section 1842 is terminated effective on the first day of the first calendar month which begins not less than thirty days after the date such notice is sent, and

"(iii) in case such entity is an entity described in paragraph (1) (B) (ii), the Secretary may notify the State having an agreement with such entity that no Federal funds shall be available with respect to any expenses incurred to compensate such entity for or on account of services performed by it pursuant to such agreement (or any similar agreement) on or after the first calendar month which begins not less than thirty days after the date such notice is sent.

In case the Comptroller General makes a request (as described in paragraph (1)) which is not fully complied with prior to the sixty-day period described in the preceding sentence, then he shall, at the earliest practicable date after the close of such period, advise the Secretary of the fact that such request was made by him and was not complied with within such period, so that the Secretary may notify the entity involved as provided in clause (i), (ii), or (iii).

"(B) Notwithstanding any other provision of law—

"(i) payments otherwise authorized to be made under title XVIII, and Federal funds otherwise available with respect to expenditures under or pursuant to

title V or XIX (or a program or plan approved thereunder) shall be subject to the limitations referred to in a notice sent by the Secretary pursuant to subparagraph (A) (i),

"(ii) agreements referred to in subparagraph (A) (ii) shall be terminated as indicated by the Secretary in a notice sent by him pursuant to subparagraph (A) (ii), and

"(iii) Federal funds otherwise available with respect to expenditures under a State plan approved under title XIX shall be subject to the limitations referred to in a notice sent by the Secretary pursuant to subparagraph (A) (iii);

except that the Secretary, for good cause shown, may terminate the application of such limitation.

"(b) Notwithstanding any other provision of law—

"(1) no payment shall be made on the basis of an assignment of benefits under title XVIII, and

"(2) no Federal funds shall be available under title V or XIX with respect to expenditures made under a State program or plan approved thereunder,

for goods and services furnished, on or after the first day of the first calendar month which begins not less than ninety days after the date of enactment of this subsection, to a patient (directly or indirectly) by any entity which is an

independent pharmacy, independent laboratory, or an independent supplier of durable medical equipment unless such entity agrees to give the Secretary or in the case of title XIX the State agency under which such entity agrees to provide to the Secretary (or any authorized officer or employee of the Department of Health, Education, and Welfare) and to the Comptroller General reasonable access to the books and records thereof which pertain to the provision of billing and payment for goods and services supplied or rendered by such entity.".

(c) Part A of title XI of such Act is amended by adding after section 1132 thereof (as added by subsection (a) of this section) the following new section:

"SHARED HEALTH FACILITY

"SEC. 1133. For purposes of this Act, the term 'shared health facility' means any arrangement whereby two or more health care practitioners, one or more of whom receives payment on a fee for service basis under titles V, XVIII, and XIX of this Act which are substantial in amount (as determined in accordance with regulations of the Secretary)—

"(1) practice their professions at a common physical location; or where a substantial number of the patients of one or more practitioners are referred to such

practitioner(s) by other practitioners or persons at a common physical location;

"(2) share (i) common waiting areas, examining rooms, treatment rooms, or other space, (ii) the services of supporting staff, or (iii) equipment, and

"(3) a person other than all of such practitioners is in charge of, controls, manages, or supervises, substantial aspects of the arrangement or operation for the delivery of health or medical services at such common physical location, other than the direct furnishing of professional health care services by such practitioners to their patients, or a person makes available to such practitioners the services of supporting staff who are not employees of such practitioners;

except that such term does not include a provider of services (as defined in section 1861(u)) or a health maintenance organization (as defined in section 1876), or an arrangement under which two or more health care practitioners practice their profession as a partnership, professional service corporation, or other legal entity, if members of the supporting staff are employees of such legal entity and in case there is an office manager, or person with similar title, he is an employee of the legal entity whose compensation is customary and not excessive for such services and there is no person described in clause (3).".

(d) The amendments made by this section shall, except as otherwise specified therein, take effect on January 1, 1977.

PENALTY FOR DEFRAUDING MEDICARE AND MEDICAID PROGRAMS

SEC. 5. (a) Section 1877 of the Social Security Act is amended—

(1) in subsection (a) thereof—

(A) by striking out "misdemeanor" and inserting in lieu thereof "felony",

(B) by striking out "one year" and inserting in lieu thereof "five years", and

(2) in subsection (b) thereof—

(A) by inserting "or arranges for the furnishing of" immediately after "Whoever furnishes",

(B) by inserting "(in cash or in kind)" immediately after "kickback or bribe",

(C) by inserting "or arrangement for the furnishing" immediately after "in connection with the furnishing",

(D) by striking out "rebate of any fee or charge" and inserting in lieu thereof "rebate of any fee, charge or portion of any payment, in cash or in kind,",

(E) by inserting "or arrangement for the fur-

nishing" immediately after "another person for the furnishing".

(F) by striking out "misdemeanor" and inserting in lieu thereof "felony", and

(G) by striking out "one year" and inserting in lieu thereof "five years", and

(3) in subsection (c) thereof—

(A) by striking out "misdemeanor" and insert- in lieu thereof "felony",

(B) by striking out "$2,000" and inserting in lieu thereof "$10,000", and

(C) by striking out "6 months" and inserting in lieu thereof "five years".

(b) Section 1909 of such Act is amended—

(1) in subsection (a) thereof—

(A) by striking out "misdemeanor" and inserting in lieu thereof "felony", and

(B) by striking out "one year" and inserting in lieu thereof "five years", and

(2) in subsection (b) thereof—

(A) by inserting "or arranges for the furnishing of" immediately after "Whoever furnishes",

(B) by inserting "in cash or in kind" immediately after "kickback or bribe",

(C) by inserting "or arrangement for the fur-

nishing" immediately after "in connection with the furnishing",

(D) by striking out "rebate of any fee or charge" and inserting in lieu thereof "rebate of any fee, charge, or portion of any payment, in cash or in kind,",

(E) by inserting "or arrangement for the furnishing immediately after "another person for the furnishing",

(F) by striking out "misdemeanor" and inserting in lieu thereof "felony", and

(G) by striking out "one year" and inserting in lieu thereof "five years", and

(3) in subsection (c) thereof—

(A) by striking out "misdemeanor" and inserting in lieu thereof "felony",

(B) by striking out "$2,000" and inserting in lieu thereof "$10,000", and

(C) by striking out "6 months" and inserting in lieu thereof "five years".

AMENDMENTS RELATED TO PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 6. (a) (2) Section 1155(g) of the Social Security Act is amended by adding at the end thereof the following new sentence: "The Secretary, where a professional

standards review organization (whether conditional or otherwise) requests review responsibility with respect to services furnished in shared health facilities, shall give priority to such request, with the highest priority being assigned to areas with substantial numbers of shared health facilities.".

(b) Section 1861 (w) (2) of such Act is amended by inserting "under part B of this title or under" immediately after "entitled to have payment made for such services under".

(c) Section 1158 of such Act is amended by adding at the end thereof the following new subsection:

"(c) Where a professional standards review organization (whether conditionally or unconditionally designated) is found competent by the Secretary to assume review responsibility with respect to specified types of health care services or specified providers or practitioners of such services and is performing such reviews, determinations made pursuant to paragraphs (1) and (2) of section 1155 (a) in connection with such reviews shall constitute the conclusive determination on those issues for purposes of payment under this Act, and no reviews with respect to such services, providers, or practitioners shall be conducted by agencies and organizations which are parties to agreements entered into by the Secretary pursuant to section 1816, carriers which are parties to contracts entered into by the Secretary pursuant

to section 1842, or State agencies administering or supervising the administration of State plans approved under title XIX.".

(d) Section 1152 (e) of such Act is amended—

(1) by inserting "(1)" immediately after "(e)", and

(2) by adding at the end thereof the following new paragraph:

"(2) Such a waiver shall not be required where the Secretary finds a professional standards review organization to be competent to assume review responsibilities with respect to specified providers of health care services. Upon such an assumption of review responsibilities by a professional standards review organization, the following provisions of this Act (to the extent they involve duplicative review and certification activities) shall (to the extent otherwise applicable) not (except to the extent otherwise specified by the Secretary) be applicable:

"(A) the provisions with respect to physician certifications required under section 1814 (a) (2) through (7), (h), and (i), and section 1835 (a) (2),

"(B) the provisions with respect to utilization review plans required under section 1861 (e) (6) and (j) (8),

"(C) the provisions with respect to medical eval-

uation and audit procedures required under section 1861 (j) (12), and

"(D) the provisions of section 1902 (a) (26), (30), (31), and (33), and section 1903 (g) and (i) (4).".

(e) Section 1166 of such Act is amended by redesignating subsection (b) thereof as subsection (c), and by inserting immediately after subsection (a) the following new subsection (b):

"(b) A professional standards review organization shall provide data and information to the responsible State and Federal agencies to assist such agencies in identifying or investigating suspected cases or patterns of fraud or abuse.".

(f) Section 1155 (b) (3) of such Act is amended by inserting "or abstract" after "examine".

(g) Section 1160 (b) (1) is amended by striking out "practitioners or providers" wherever it appears and inserting in lieu thereof "health care practitioners or any hospital, or other health care facility, agency or organization".

(h) Section 1168 of such Act is amended by inserting, immediately after the first sentence thereof, the following:

"Nothing herein shall be construed to authorize or require any contribution by a State (or any political subdivision thereof) toward, or as a condition of the availability for purposes of the administration of this part, of any of the funds described in clause (c) of the preceding sentence.".

94TH CONGRESS
2D SESSION

H. R. 13347

IN THE HOUSE OF REPRESENTATIVES

APRIL 27, 1976

Mr. SCHEUER introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend title XIX of the Social Security Act to provide for effective detection and prevention of fraud and abuse in connection with the medical assistance program under that title.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That title XIX of the Social Security Act is amended by adding after section 1910 the following new section:

"DETECTION AND PREVENTION OF FRAUD AND ABUSE

"SEC. 1911. (a) The Secretary shall establish within the Department of Health, Education, and Welfare an identifiable administrative entity to establish and administer a system for the detection and prevention of fraud and abuse

in the provision of medical assistance under this title. Such unit shall be given appropriate authority for the effective administration of such a system, including authority for inspections and audits.

"(b) (1) The entity established under subsection (a) shall compile, keep current, and make available to State agencies a list of persons who have been convicted of a violation which is described in section 1909 and which was made in connection with the furnishing by such persons of items and services to individuals for which payment was or was to be made under a State plan approved under this title.

"(2) Such entity shall, upon request, provide investigative support and assistance to United States attorneys in connection with prosecutions for violations described in section 1909.

"(3) A person listed under paragraph (1) for a conviction of a violation occurring after the date of enactment of this section shall during the six-month period beginning on the date such conviction became final be ineligible to receive any payment under title XVIII or under a State plan approved under this title for the furnishing after such date of items or services to any individual.

"(c) The Secretary shall report on a semiannual basis to Congress and to the State agencies the extent and scope

of activities carried out by the entity established pursuant to subsection (a).".

SEC. 2. (a) Section 1902 (a) of the Social Security Act is amended (1) by striking out "and" at the end of paragraph (35); (2) by striking out the period at the end of paragraph (36) and inserting in lieu thereof "; and"; and (3) by adding after paragraph (36) the following new paragraphs:

"(37) provide for the designation or establishment and operation of an identifiable administrative entity of the State government which will (A) establish and administer a system for the detection and prevention of fraud and abuse within the State in connection with the provision of medical assistance under the plan, and (B) report to the entity established under section 1911 every three months on the scope and extent of the State entity's activities; and

"(38) provide for the use of (A) information retrieval systems capable of providing profiles of persons paid under the plan in connection with furnishing of items and services to individuals and of individuals receiving such items and services, and (B) such uniform billing and claim system as the Secretary may prescribe.".

(b) Section 1903(a)(3)(A)(i) of such Act is amended by inserting before "as the Secretary" the following: "(including, for purposes of assisting in the detection and prevention of fraud and abuse in connection with the provision of medical assistance under the plan, systems under an approved plan which will provide profiles of persons paid under the plan in connection with furnishing of items and services and of individuals receiving such items and services)".

(c) Section 1903(a)(4) of the Social Security Act is amended (1) by inserting "(A)" after "attributable to", and by inserting after "this Act" the following: ", and (B) the cost of the establishment or operation, or both, of the entity described in section 1902(a)(37) if such cost was incurred during a quarter in whole or in part within the first thirty-six months of such entity's carrying out a function described in such section".

SEC. 3. (a) There is established a commission (policy to be supplied respecting who establishes, who are members, qualifications of members) to conduct a study of fraud and abuse in connection with the furnishing of health care in the United States and the payment and reimbursement under both public and private systems for the cost of furnishing such care.

(b) The Commission shall complete the study required by subsection (a) within two years of the date of the enactment of this Act and shall, within thirty days of the completion of the study, make a report respecting the results of such study to the Committees on Finance and Labor and Public Welfare of the Senate and the Committees on Interstate and Foreign Commerce and Ways and Means of the House of Representatives.

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94TH CONGRESS
2D SESSION

H. R. 14805

IN THE HOUSE OF REPRESENTATIVES

JULY 21, 1976

Mr. SCHEUER (for himself, Mr. MOSS, and Mr. MAGUIRE) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend title XIX of the Social Security Act to provide a mechanism for the more effective detection and prevention of fraud and abuse in connection with the medical assistance program under that title.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Medical Assistance Accountability Act of 1976".

SEC. 2. Title XIX of the Social Security Act is amended by adding at the end thereof the following new section:

"SPECIAL AUDITOR GENERAL FOR MEDICAID FRAUD AND ABUSE

"SEC. 1911. (a) (1) In addition to other officers within the Department of Health, Education, and Welfare, there shall be, within such Department, an officer with the title of 'Special Auditor General for Medicaid Fraud and Abuse' (hereinafter in this section referred to as the 'Auditor General'), who shall be appointed initially and reappointed on or after February 1, 1977, by the President, by and with the advice and consent of the Senate. In addition, there shall be a Deputy Special Auditor General for Medicaid Fraud and Abuse (hereinafter referred to as the 'Deputy Auditor General'), and such additional personnel as may be required to carry out the functions vested in the Auditor General by this section.

"(2) The term of office of any individual appointed or reappointed to the position of Auditor General shall expire six years after the date he takes office pursuant to such appointment or reappointment.

"(b) The Auditor General shall report directly to the Secretary of Health, Education, and Welfare (hereinafter in this section referred to as the 'Secretary'); and, in carrying out the functions vested in him by this section, the Auditor General shall not be under the control of, or subject to supervision by, any officer of the Department of Health,

Education, and Welfare having administrative or program responsibilities with respect to medical assistance programs under this title.

"(c) (1) It shall be the duty and responsibility of the Auditor General to arrange for, direct, or conduct such reviews, inspections, and audits of the medical assistance programs established pursuant to this title as he considers necessary for ascertaining the efficiency and economy of their administration, their consonance with the provisions of this title, and the attainment of the objectives and purposes for which this title was enacted.

"(2) The Auditor General shall maintain continuous observation and review of programs with respect to which he has responsibilities under paragraph (1) of this subsection for the purpose of—

"(A) determining the extent to which such programs are in compliance with applicable laws and regulations;

"(B) making recommendations for the correction of deficiencies in, or for improving the organization, plans, procedures, or administration of, such programs; and

"(C) evaluating the effectiveness of such programs in attaining the objectives and purposes of the provisions of this title.

"(d) (1) For purposes of aiding in carrying out his duties under this section, the Auditor General shall have access to all records, reports, audits, reviews, documents, papers, recommendations, or other material available to the Department of Health, Education, and Welfare which relate to the administration of this title or to the medical assistance programs established pursuant to this title.

"(2) The head of any Federal department, agency, office, or instrumentality shall, and the head of any State agency administering or supervising the administration of any State plan approved under this title shall, at the request of the Auditor General, provide any information which the Auditor General determines will be helpful to him in carrying out his responsibilities under this section.

"(3) The Auditor General may refer directly to any other departments or agencies (including other officers and agencies of the Department of Health, Education, and Welfare) for appropriate consideration and action such matters and cases as may be within their areas of concern and responsibility, including information concerning any failure by a provider of health services to maintain adequate standards or comply with applicable provisions of law which may affect or involve such provider's status or compliance under other Federal health care or related programs within such areas.

"(4) The Auditor General may, in his discretion, provide assistance within his competence, with the approval of the Secretary, to any department, agency, or subagency of the Federal Government upon request of the chief officer of such department or agency.

"(e) (1) The Auditor General shall submit reports on a semiannual basis to the Committee on Finance of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives, and to any duly authorized subcommittees thereof having legislative or oversight jurisdiction over the matters involved, with respect to his activities under this section.

"(2) Whenever any of the committees or subcommittees referred to in paragraph (1) makes a request to the Auditor General to furnish such committee or subcommittee with any information, or to conduct any study or investigation and report the findings resulting therefrom to such committee or subcommittee, the Auditor General shall comply with such request.

"(f) The Auditor General may make expenditures (not in excess of $100,00 in any fiscal year) of a confidential nature when he finds that such expenditures are in aid of inspections, audits, or reviews under this section; but such expenditures so made shall not be utilized to make payments, to any one individual, the aggregate of which

exceeds $5,000. The Auditor General shall submit annually a confidential report on expenditures under this provision to the Committee on Finance of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives and to any duly authorized subcommittee of either having legislative or oversight jurisdiction over the matters involved.

"(g) (1) Expenses of the Auditor General under this section shall be payable from funds appropriated to carry out this title.

"(2) Notwithstanding any other provision of law, personnel requirements for the Office of the Auditor General shall not be subject to numerical or budgetary limitation. The personnel and budgetary requirements of such units shall be submitted as 'line items' by the President in the submission of his budget.

"(3) Whenever the Auditor General submits any budget estimate or request to the Secretary, the President, or the Office of Management and Budget, he shall concurrently transmit a copy of that estimate or request to the Congress.

"(4) There are hereby authorized to be appropriated (as a part of the funds specified in paragraph (1)) such sums as may be necessary to carry out the purposes of this section.

"(h) The Secretary shall provide the Auditor General

and his staff with appropriate and adequate office space within the central and regional facilities of the Department of Health, Education, and Welfare, together with such equipment, office supplies, and communications facilities and services, as may be necessary for the operation of such office and shall provide necessary maintenance services for such office and the equipment and facilities located therein.

"(i) (1) The Auditor General shall compile, keep current, and make available to State agencies a list of persons who have been convicted of a violation which is described in section 1909 and which was made in connection with the furnishing by such persons of items and services to individuals for which payment was or was to be made under a State plan approved under this title.

"(2) The Auditor General shall, upon request, provide investigative support and assistance to United States attorneys in connection with prosecutions for violations described in section 1909.

"(3) A person listed under paragraph (1) for a conviction of a violation occurring after the date of the enactment of this section shall, during the two-year period beginning on the date such conviction became final, be ineligible to receive any payment under a State plan approved under this title for the furnishing after such date of items or services to any individual.

"(j) For the purpose of carrying out his responsibilities under this section—

"(1) the Auditor General may—

"(A) sign and issue subpenas for the attendance and testimony of witnesses and the production of books, records, papers, and other documents;

"(B) require any person, by general or special order, to submit answers in writing to interrogatories, to submit books, records, papers, or other documents, or to submit any other information or reports, and such answers or other submissions shall be made within such reasonable period, and under oath or otherwise, as the Auditor General may determine; and

"(C) administer oaths; and

"(2) The Auditor General, or any officer or employee duly designated by the Auditor General, upon presenting appropriate credentials and a written notice from the Auditor General to the owner, operator, or agent in charge, may—

"(A) enter, at reasonable times, any business premise or facility; and

"(B) inspect, at reasonable times and in a reasonable manner, any such premise or facility,

inventory and sample any stock of energy resources therein, and examine and copy books, records, papers, or other documents, relating to any such energy information.

Upon petition by the Auditor General through any attorney employed or designated by him, or, upon request of the Auditor General, the Attorney General, any appropriate United States district court may, in the case of a refusal to obey a subpena issued or requirement imposed under paragraph (1), or in the case of a refusal to permit entry or inspection under paragraph (2), issue an order requiring compliance with such subpena or requirement or permission for such entry or inspection; and any failure to obey the order of the court may be punished by the court as a contempt thereof.".

(b) Section 5315 of title 5, United States Code, is amended by adding at the end thereof the following new paragraph:

"(108) Special Auditor General for Medicaid Fraud and Abuse.".

SEC. 3. (a) Section 1902(a) of the Social Security Act is amended—

(1) by striking out "and" at the end of paragraph (35);

(2) by striking out the period at the end of paragraph (36) and inserting in lieu thereof a semicolon; and

(3) by inserting after paragraph (36) the following new paragraphs:

"(37) provide for the designation or establishment and operation of an identifiable administrative entity of the State government which will (A) establish and administer a system for the detection and prevention of fraud and abuse within the State in connection with the provision of medical assistance under the plan, and (B) report to the Special Auditor General for Medicaid Fraud and Abuse every three months on the scope and extent of the State entity's activities; and

"(38) provide for the use of (A) information retrieval systems capable of providing profiles of persons paid under the plan in connection with furnishing of items and services to individuals and of individuals receiving such items and services, and (B) such uniform billing and claim system as the Auditor General may prescribe.".

(b) Section 1903 (a) (3) (A) of such Act is amended—

(1) by striking out "and" at the end of clause (i); and

(2) by adding after clause (ii) the following new clause:

"(iii) 90 per centum of so much of the sums expended during such quarter for the purpose of assisting in the detection and prevention of fraud and abuse in connection with the provision of medical assistance under the plan, and for the purpose of establishing or administering information retrieval systems described in section 1902(a)(38)(A), as the Special Auditor General for Medicaid Fraud and Abuse determines are likely to provide more efficiently for the elimination of fraud and abuse within the administration of the plan, and".

(c) Section 1903(a)(4) of the Social Security Act is amended by inserting "(A)" after "attributable to", and by inserting after "this Act" the following: ", and (B) the cost of the establishment or operation, or both, of the State entity described in section 1902(a)(37) during any quarter which falls in whole or in part within the first thirty-six months of such entity's carrying out a function described in such section".

SEC. 4. (a) The Special Auditor General for Medicaid Fraud and Abuse shall conduct a study of fraud and abuse in connection with the furnishing of health care in the United

States and the payment and reimbursement under both public and private systems for the cost of furnishing such care. In the conduct of such study the Special Auditor General shall have the powers specified in section 1911 (j) of the Social Security Act.

(b) The Auditor General shall complete the study required by subsection (a) within two years after the date of the enactment of this Act and shall, within thirty days of the completion of the study, make a report respecting the results of such study to the Committees on Finance and Labor and Public Welfare of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives.

94TH CONGRESS
1ST SESSION

H. R. 6483

IN THE HOUSE OF REPRESENTATIVES

APRIL 29, 1975

Mr. PEPPER (for himself and Mr. KOCH) introduced the following bill; which was referred to the Committees on Ways and Means and Interstate and Foreign Commerce

A BILL

To amend the Social Security Act to provide for the establishment of an Inspector General for health administration.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) title XI of the Social Security Act is amended by adding after section 1123 the following new section:

"INSPECTOR GENERAL FOR HEALTH ADMINISTRATION

"SEC. 1125. (a) (1) In addition to other officers within the Department of Health, Education, and Welfare, there shall be, within such department, an officer with the title of 'Inspector General for Health Administration' (hereinafter in this section referred to as the 'Inspector General') who

shall be appointed or reappointed by the President, by and with the advice and consent of the Senate. In addition, there shall be a Deputy Inspector General for Health Administration (hereinafter referred to as the 'Deputy Inspector General'), and such additional personnel as may be required to carry out the functions vested in the Inspector General by this section.

"(2) The term of office of any individual appointed or reappointed to the position of Inspector General shall expire six years after the date he takes office pursuant to such appointment or reappointment.

"(b) The Inspector General shall report directly to the Secretary of Health, Education, and Welfare (hereinafter in this section referred to as the 'Secretary'); and, in carrying out the functions vested in him by this section, the Inspector General shall not be under the control of, or subject to the supervision by, any officer of the Department of Health, Education, and Welfare, other than the Secretary.

"(c) (1) It shall be the duty and responsibility of the Inspector General to arrange for, direct, or conduct such reviews, inspections, and audits of the health insurance program established by title XVIII, the medical assistance programs established pursuant to title XIX and any other programs of health care authorized under any other title of this Act as he considers necessary for ascertaining the effi-

ciency and economy of their administration, their consonance with the provisions of law by or pursuant to which such programs were established, and the attainment of the objectives and purposes for which such provisions of law were enacted.

"(2) The Inspector General shall maintain continuous observation and review of programs with respect to which he has responsibilities under paragraph (1) of this subsection for the purpose of—

"(A) determining the extent to which such programs are in compliance with applicable laws and regulations;

"(B) making recommendations for the correction of deficiencies in, or for improving the organization, plans, procedures, or administration of such programs; and

"(C) evaluating the effectiveness of such programs in attaining the objectives and purposes of the provisions of law by or pursuant to which such programs were established.

"(d) (1) For the purposes of aiding and carrying out his duties under this section, the Inspector General shall have access to all records, reports, audits, reviews, documents, papers, recommendations, or other material of or available to the Department of Health, Education, and Welfare which

relate to the programs with respect to which the Inspector General has responsibilities under this section.

"(2) The head of any Federal department, agency, office, or instrumentality shall at the request of the Inspector General, provide any information which the Inspector General determines will be helpful to him in carrying out his responsibilities under this section.

"(e) (1) The Inspector General shall have the authority to suspend any regulation, practice, or procedure employed in the administration of any program with respect to which he has responsibilities under this section if as a result of any study, investigation, review, or audit of such program, he determines that—

"(A) the suspension of such regulation, practice, or procedure will promote efficiency or economy in the administration of such program; or

"(B) such regulation, practice, or procedure is contrary to the applicable provisions of law, or does not carry out the objectives and purposes of the provisions of law by or pursuant to which there was established the program in connection with which such regulation, practice, or procedure is promulgated, instituted, or applied.

"(2) (A) Any suspension by the Inspector General of any regulation, practice, or procedure pursuant to this sub-

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section shall remain in effect until the Inspector General issues an order reinstating such regulation, practice, or procedure; except that—

"(i) in the case of any existing regulation, the Secretary may, at any time after such suspension by the Inspector General, issue an order revoking such suspension, and

"(ii) in the case of a suspension of a practice or procedure or the application of a proposed regulation, the Secretary may, at any time later than thirty days after any such suspension by the Inspector General, issue an order revoking such suspension.

"(B) Whenever the Secretary issues an order revoking any such suspension by the Inspector General, he shall promptly notify the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives of such order and shall submit to each such committee information explaining his reasons for the issuance of such order.

"(f) (1) The Inspector General may, from time to time submit such reports to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives relating to his activities as he deems to be appropriate.

"(2) Whenever either of the committees referred to

in paragraph (1) makes a request to the Inspector General to furnish such committee with any information, or to conduct any study or investigation and report the findings resulting therefrom to such committee, the Inspector General shall comply with such request.

"(3) Whenever the Inspector General issues an order suspending or reinstating any regulation, practice, or procedure pursuant to subsection (e) he shall promptly notify the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives of such order and shall submit to each such committee information explaining the reasons for the issuance of such order.

"(g) The Inspector General may make expenditures (not in excess of $50,000 in any fiscal year) of a confidential nature when he finds that such expenditures are in aid of inspections, audits, or reviews under this section; but such expenditures so made shall not be utilized to make payments to any one individual, the aggregate of which exceeds $2,000. The Inspector General shall submit annually a confidential report on expenditures under this provision to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

"(h) (1) Expenses of the Inspector General relating to the health insurance program established by title XVIII shall be payable from the Federal Hospital Insurance Trust

Fund and from the Federal Supplementary Medical Insurance Trust Fund, with such portions being paid from each such fund as the Secretary shall deem to be appropriate. Expenses of the Inspector General relating to medical assistance programs established pursuant to title XIX shall be payable from funds appropriated to carry out such title; and expenses of the Inspector General relating to any program of health care authorized under any title of this Act (other than titles XVIII and XIX) shall be payable from funds appropriated to carry out such program.

"(2) There are hereby authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.

"(i) The Secretary shall provide the Inspector General and his staff with appropriate office space within the facilities of the Department of Health, Education, and Welfare together with such equipment, office supplies, and communications facilities and services as may be necessary for the operation of such office and shall provide necessary maintenance services for such offices and the equipment and facilities located therein.".

(b) Section 5315 of title 5, United States Code, is amended by inserting:

"(105) Inspector General for Health Administration.".

94TH CONGRESS
1ST SESSION

H. R. 6623

IN THE HOUSE OF REPRESENTATIVES

MAY 1, 1975

Mr. VANIK introduced the following bill; which was referred to the Committees on Ways and Means and Interstate and Foreign Commerce

A BILL

To amend title XI of the Social Security Act to provide for a system of reviews, inspections, and audits of the medicare program under title XVIII of such Act, to be conducted by a newly established Inspector General for Health Administration in the Department of Health, Education, and Welfare.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That part A of title XI of the Social Security Act is amended by adding at the end thereof the following new section:

"INSPECTOR GENERAL FOR HEALTH ADMINISTRATION

"SEC. 1124. (a) (1) In addition to other officers within the Department of Health, Education, and Welfare, there shall be within such Department an officer with the title of

'Inspector General for Health Administration' (hereinafter in this section referred to as the 'Inspector General'), who shall be appointed or reappointed by the President, by and with the advice and consent of the Senate. In addition, there shall be a Deputy Inspector General for Health Administration (hereinafter referred to as the 'Deputy Inspector General'), and such additional personnel as may be required to carry out the functions vested in the Inspector General by this section.

"(2) The term of office of any individual appointed or reappointed to the position of Inspector General shall expire six years after the date he takes office pursuant to such appointment or reappointment.

"(b) The Inspector General shall report directly to the Secretary of Health, Education, and Welfare (hereinafter in this section referred to as the 'Secretary'); and, in carrying out the functions vested in him by this section, the Inspector General shall not be under the control of, or subject to supervision by, any officer of the Department of Health, Education, and Welfare other than the Secretary.

"(c) (1) It shall be the duty and responsibility of the Inspector General to arrange for, direct, or conduct such reviews, inspections, and audits of the health insurance program established by title XVIII, and any other programs of health care authorized under any other title of this Act, as

he considers necessary for ascertaining the efficiency and economy of their administration, their consonance with the provisions of law by or pursuant to which such programs were established, and the attainment of the objectives and purposes for which such provisions of law were enacted.

"(2) The Inspector General shall maintain continuous observation and review of programs with respect to which he has responsibilities under paragraph (1) of this subsection for the purpose of—

"(A) determining the extent to which such programs are in compliance with applicable laws and regulations;

"(B) making recommendations for the correction of deficiencies in, or for improving the organization, plans, procedures, or administration of, such programs; and

"(C) evaluating the effectiveness of such programs in attaining the objectives and purposes of the provisions of law by or pursuant to which such programs were established.

"(d) (1) For purposes of aiding in carrying out his duties under this section, the Inspector General shall have access to all records, reports, audits, reviews, documents, papers, recommendations, or other material of or available to the Department of Health, Education, and Welfare which

relate to the programs with respect to which the Inspector General has responsibilities under this section.

"(2) The head of any Federal department, agency, office, or instrumentality shall, at the request of the Inspector General, provide any information which the Inspector General determines will be helpful to him in carrying out his responsibilities under this section.

"(c) (1) The Inspector General shall have authority to suspend any regulation, practice, or procedure employed in the administration of any program with respect to which he has responsibilities under this section if, as a result of any study, investigation, review, or audit of such program, he determines that—

"(A) the suspension of such regulation, practice, or procedure will promote efficiency or economy in the administration of such program; or

"(B) such regulation, practice, or procedure is contrary to applicable provisions of law, or does not carry out the objectives and purposes of the provisions of law by or pursuant to which there was established the program in connection with which such regulation, practice, or procedure is promulgated, instituted, or applied.

"(2) (A) Any order of suspension by the Inspector General of any regulation, practice, or procedure pursuant

to this subsection shall remain in effect until the Inspector General issues an order reinstating such regulation, practice, or procedure; except that the Secretary shall receive not less than thirty days notice of the proposed suspension and may, at any time prior to or after any such suspension by the Inspector General, issue an order revoking such suspension.

"(B) Whenever the Secretary issues an order revoking any such actual or proposed order of suspension by the Inspector General, he shall promptly notify the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate of such order and shall submit to each such committee information explaining his reasons for the issuance of such order.

"(f) (1) The Inspector General may, from time to time, submit such reports to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate relating to his activities as he deems to be appropriate.

"(2) Whenever either of the committees referred to in paragraph (1) makes a request to the Inspector General to furnish such committee with any information, or to conduct any study or investigation and report the findings resulting therefrom to such committee, the Inspector General shall comply with such request.

"(3) Whenever the Inspector General issues an order

suspending or reinstating any regulation, practice, or procedures pursuant to subsection (c), he shall promptly notify the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate of such order and shall submit to each such Committee information explaining his reasons for the issuance of such order.

"(g) (1) Expenses of the Inspector General relating to the health insurance program established by title XVIII shall be payable from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, with such portions being paid from each such fund as the Secretary shall deem to be appropriate; and expenses of the Inspector General relating to any program of health care authorized under any title of this Act (other than title XVIII) shall be payable from funds appropriated to carry out such program.

"(2) There are hereby authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.

"(h) The Secretary shall provide the Inspector General and his staff with appropriate and adequate office space within the facilities of the Department of Health, Education, and Welfare, together with such equipment, office supplies, and

communications facilities and services, as may be necessary for the operation of such office and shall provide necessary maintenance services for such office and the equipment and facilities therein.".

Mr. Rogers. Our first witnesses today will be from the Department of Health, Education, and Welfare, Dr. William A. Morrill, who is the Assistant Secretary for Planning and Evaluation; he is accompanied by Mr. Gene Haislip, who is Deputy Assistant Secretary for Legislation, Dr. Keith Weikel, who is Commissioner of the Medical Services Administration, Thomas M. Tierney, who is Director of the Bureau of Health Insurance, John Walsh, Director of Office of Investigation, and Dr. Michael J. Goran, Director, Bureau of Quality Assurance. We welcome each of you to the committee and you may proceed. Your statement will be made a part of the record.

STATEMENT OF WILLIAM A. MORRILL, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY GENE R. HAISLIP, DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH); KEITH M. WEIKEL, PH. D., COMMISSIONER, MEDICAL SERVICES ADMINISTRATION, SOCIAL REHABILITATION SERVICE; THOMAS M. TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE, SOCIAL SECURITY ADMINISTRATION; JOHN WALSH, DIRECTOR, OFFICE OF INVESTIGATIONS; MICHAEL J. GORAN, M.D., DIRECTOR, BUREAU OF QUALITY ASSURANCE, HEALTH SERVICES ADMINISTRATION

Mr. Morrill. Thank you very much. Mr. Chairman, members of the committee, I appreciate the opportunity to appear before you today to express our views on the Medicare-Medicaid Anti-Fraud Amendments, H.R. 15536, and to discuss also H.R. 15390, a bill to establish an Office of the Inspector General in HEW.

As we begin this hearing I would like to state that the Department shares your concern and objective in assuring that program fraud and abuse is brought under control and that sufficient steps are undertaken to deal with fraud and abuse at all organizational levels—Federal, State and local—where the various programs are administered. At the same time, the administration believes that fundamental reforms in medicaid are necessary and that more Federal employees, more Federal regulations, and more Federal procedures are not a longrun answer. Nevertheless, until such time as changes are made, we must aggressively move in the short run to take steps to assure that States will control medicaid fraud and abuse.

BACKGROUND

Before speaking directly to the bill under immediate consideration, I would like to briefly review the Department's recent actions to combat fraud and program abuse.

Elimination of criminal activity which may occur as HEW programs are carried out in communities across the country is a continuing and critical management responsibility of high priority. Last December Secretary Mathews issued a reorganization order establishing an independent Office of Investigations, reporting directly to the Under Secretary. He then delegated to the Director of that office authority to conduct investigations of alleged causes of malfeasance,

fraud and misuse of funds without prior approval of higher authority. To support this initiative more adequately, in January of 1976, with the authorization of the Congress, the new office was granted additional positions, some of which were dedicated to the support of medicaid fraud and abuse control. At the same time the Medical Services Administration received authorization for additional staff to strengthen its oversight capability.

MEDICAL EFFORTS

In March of this year a major Federal-State campaign was launched to reduce fraud and abuse and improve the management of the medicaid program. Teams of Federal medicaid examiners in concert with State medicaid program staff will conduct reviews in at least 10 States the first year. At the invitation of the Governors of Massachusetts and Ohio, the examiners have started working in those two States. In addition to identifying the kinds and causes of fraud and abuse, these examiners will refer specific violations to the State for further criminal investigation.

In the medicaid program there have been over 7,000 investigations begun in the first 9 months of fiscal year 1976. Of these cases, 261 have been referred to law enforcement officials. In addition, there have been 47 convictions and approximately $1.4 million recovered in the first 9 months of fiscal year 1976. Finally, 400 providers have been terminated or suspended during this period.

Another step we have begun in order to deal more effectively with potential violations is to work more closely with law enforcement authorities. Specifically, in this regard, the Department through the use of SRS staff and the Office of Investigations recently provided 20 staff years of support to the U.S. attorneys in their investigation of medicaid fraud and abuse in New York.

We recognize that a substantial contribution to the control of fraud and abuse can be made by effective management throughout program operations. The primary responsibility for management of the medicaid program is a State task. To assist the States we have developed and made available a medicaid management information system. Ten States now use the system and 20 more have it under development. Additionally, we are working with a coalition of State and local government organizations to improve management of the medicaid program generally.

MEDICARE

The basic medicare administrative system includes quality control and verification procedures that result in disallowance of many millions of dollars in claims against the program each year.

Situations involving an apparent attempt to defraud or abuse the program are referred to special program integrity staffs. Each of the 10 Bureau of Health Insurance—BHI—regional offices has such a staff in place. These regional staffs are responsible for the development and presentation to U.S. attorneys of cases of fraud and the correction of cases of abuse.

To date, BHI regional office staffs have investigated approximately 23,000 incidents or situations for the possibility of fraud and approximately 21,000 instances of possible abuse. In most cases, preliminary

investigation of a suspect incident reveals a processing error by the contractor or a misunderstanding on the part of the beneficiary rather than an erroneous action by the physician or supplier. As of June 30, 1976, these investigations have led to 578 cases being referred to the Department of Justice with a recommendation for prosecution. To date, there have been 186 convictions and 181 cases are awaiting trial or action by the U.S. Attorney.

RECENT DEPARTMENTAL INITIATIVES

As part of his continuing program to strengthen departmentwide fraud and abuse activities, Secretary Mathews, on September 13, directed that an Office of Audits and Investigations be established, combining the functions being carried out by the Office of Investigations and the HEW Audit Agency. The Director of this new office will report directly to the Secretary, and will operate under a broad mandate with the authority to conduct and supervise audits and investigations relating to the programs of HEW. In addition, it will have a major role in activities designed to promote economy and efficiency in the administration of these programs. This change will provide a single-management focus for day-to-day oversight and coordination of audit and investigative functions in all program areas. Additionally, to deal with the peculiar facets of health financing, we intend to develop some specialized capabilities to support the specific efforts to prevent, detect, and investigate fraud and abuse in medicare and medicaid.

These ongoing efforts and new initiatives give evidence of our belief that sufficient authority now exists to accomplish the major objectives of curtailing fraud and abuse and increasing program efficiency as well.

H.R. 15536

The bill under consideration before your committee, H.R. 15536, would establish an Office of Central Fraud and Abuse Control, which would have overall responsibility to direct, coordinate, and make policy with respect to fraud and abuse monitoring and investigation at all organizational levels in medicare and medicaid. This unit could also initiate and conduct investigations of suspected criminal fraud and abuse in these programs, and would assist State agencies, at their request, in the establishment and operation of State antifraud and abuse activities. The Office would also provide all appropriate investigative support and assistance—including temporary delegation and assignment of personnel—to U.S. attorneys and State law enforcement authorities, upon their request, in the development of fraud cases arising out of these programs.

As we have stated, to deal with the peculiar facets of health financing, we plan to develop some specialized staff expertise to support audit and criminal investigatory efforts. We also plan to develop some specialized competence in other major program areas. However, we oppose the proposed establishment of an independent office to deal solely with these problems, separate and distinct from overall Department oversight and investigative efforts associated with combating program fraud and abuse, because it would be counterproductive in reaching the objective which the Department shares with this committee.

By splintering the investigative functions, requirements for departmental resources would be unnecessarily duplicated and their potential impact diluted. We would lose the ability to target our resources for specified periods of time on major problem areas. Also, we might not be able to profit from experience gained in investigating fraud in programmatic areas other than medicaid and medicare. Moreover, there would be no one office in the Department providing the necessary day-to-day management to assure that all fraud and abuse prevention, detection, and investigative activities are conducted in accordance with a consistent departmental policy. Of great importance, too, is that this provision would not allow, in our view, the Department the flexibility to determine how and where it should direct its investigation efforts.

In view of these major organizational and operating disadvantages, we do not support this provision.

OTHER PENDING LEGISLATION

While we believe that sufficient authority now exists to accomplish the objectives of reducing fraud and abuse and increasing program efficiency, a bill pending before the Congress, H.R. 15390, would give additional impetus to the steps we have already taken. This legislation would establish an Office of Inspector General within the Department. While we believe certain modifications are desirable, nevertheless, we would support passage of this bill, inasmuch as the primary objective of the bill is the placement of the audit and investigative functions of the Department under one director, reporting to the Secretary.

Enactment of H.R. 15390 would place into statute an Office of Inspector Gneral, provide a certain degree of permanence in its establishment, and enhance its operational role in the non-Federal areas. H.R. 15390 would establish two new executive level positions for this Office. No such positions now exist at this level for utilization in the new Office of Audits and Investigations.

As I indicated, we plan to develop specialized health financing staff capability in our newly formed Office of Audits and Investigations. To formalize this objective in the new Office of Inspector General, we would propose that H.R. 15536 be amended to incorporate the provisions of H.R. 15390 in lieu of its provision establishing an Office of Central Fraud and Abuse Control. Moreover, we would accept that within the Office of Inspector General there would be established an Office of Health Financing Fraud and Abuse Control. While we are generally opposed to statutory provisions establishing subordinate organizations, the apparent need to focus on the health financing programs warrants an exception to our general view. This unit in the inspector general's office would be responsible for directing, coordinating, monitoring, and establishing policies with respect to the undertaking of activities designed to control all fraud and financial abuse that may occur in connection with any program under titles V, XVIII, XIX, or section 226(g) of the Social Security Act.

The unit shall, within the limits of its resources, also provide appropriate investigative support and assistance to U.S. attorneys and State law enforcement authorities, upon their request, in the development of fraud cases arising out of any such programs. This unit would be

headed by an assistant inspector general appointed by the inspector general.

H.R. 15390 also contains a few other provisions which we recommend be modified when they are incorporated into H.R. 15536. This bill contains inappropriate reporting requirements, which would provide that the inspector general report to both the Secretary and Congress whenever the inspector general became aware of serious problems, abuses, or deficiencies relating to HEW programs or operations. We propose that the inspector general report flagrant problems immediately to the Secretary, the person directly responsible and accountable for administration of the program, who would in turn promptly report such problems to the Congress.

I might note, Mr. Chairman, the letter you read this morning from Chairman Fountain clearly made a substantial move in the direction of addressing some of our concerns.

It would also direct the inspector general to inform Congress about intraexecutive branch budget actions that he considered to be seriously detrimental to his adequate performance. We recommend that this provision be deleted because this special privilege of the inspector general's would threaten to undermine the Secretary's and the President's ability to manage the Department's budget in an evenhanded fashion. Moreover, the provision would not provide the Congress with information not otherwise made available to it in the course of its consideration of the President's budget.

The bill also contains an authorization for hold-harmless provisions for career and executive schedule personnel transferred to the new Office of Inspector General. We propose deletion of this provision as the Civil Service Commission's view is that officials and staff of the new office should be compensated solely on the basis of their job functions and personal qualifications.

To summarize, on the organizational issue, Mr. Chairman, we believe that both the committee's and the Department's common objective can best be achieved by amending H.R. 15536 to establish an Office of the Inspector General and to assure a separate focus within that Office to support activities related to fraud and abuse in the health financing program. We believe this to be the most efficient and cost-effective management solution.

OTHER PROVISIONS OF H.R. 15536

Returning now to H.R. 15536, I would like to present the Department's views regarding some other provisions in this bill.

Section 3 clarifies that the prohibition against assigning medicare and medicaid claims to third parties, such as factoring firms, also applies to situations where a practitioner or provider tries to bypass the prohibition by using a power of attorney. While we favor this provision, we feel it should be modified to give the Secretary discretionary authority to permit such arrangements in situations which would not adversely affect medical care costs or result in other abuses. Although there is a need to eliminate factoring, we would not want to interfere with common and legitimate business arrangements between physicians and other entities, including legitimate billing agents.

Additionally, the language of the bill should be clarified to state specifically that this provision applies to all types of practitioners and providers.

As you may be aware, HEW regulations prohibit payment for service to or through a factor for all providers other than those reimbursed on a reasonable cost basis. The regulations were based upon congressional intent expressed in the reports accompanying P.L. 92–603.

HEW published regulations also to cover the prohibition against factoring through the power of attorney mechanism and include the requirement that compensation for business services must not be related on a percentage or other basis to the dollar amounts to be billed or collected.

We also favor the provision that would require disclosure of information concerning ownership and business dealings between providers and suppliers of services participating in the medicare and medicaid programs. Because this information is intended to illuminate possible inside dealing, we would propose to limit the requirement to the disclosure of persons who hold at least 5 percent of the ownership of the provider or supplier, or 5 percent of its property or financial obligations. Requiring the disclosure of insignificant ownership interests would create administrative burdens for providers and suppliers with no corresponding advantage to the program.

We also support the provision which defines fraudulent acts and false reporting as felonies and would recommend the current $10,000 penalty be increased to $25,000.

Finally, the bill would amend the PSRO statute in order to encourage PSRO's to perform review of shared health facilities, or the so-called medicaid mills. The amendment allows the PSRO's to request from the Secretary responsibility for the review of shared health facilities and the Secretary, in turn, is required to give highest priority to these requests.

We do not object to this provision, but would raise a note of caution. In our view, PSRO's are the most appropriate organizations to address flaws in the area of quality of care, but we must recognize that they are relatively new and essentially untried in ambulatory care review. We believe it should be the responsibility of the profession to perform this review, and PSRO's are essentially the only organized system throughout much of the country designed to deal with the difficult problems of assuring the quality of care.

But we should not expect too much to soon. Few PSRO's have had experience performing ambulatory care review. Most of them began this review prior to their designation as a conditional PSRO under the research program called EMCRO—experimental medical review care organizations—or for the States. We recently funded six PSRO's to begin ambulatory review on a demonstration basis and in this process received requests from about 25 PSRO's. Thus, there is growing interest on the part of physicians to perform this review.

We must be acutely aware of the significant distinction between fraud and abuse. PSRO's are not and should not be responsible for the investigation of fraud; they address issues of the quality of medical practice and this includes overutilization or misutilization, which are

aspects of abuse. In contrast, fraud is a criminal act, and should be the responsibility of others.

The confidentiality provision of the PSRO law is also amended in an attempt, we assume, to permit PSRO's to report their findings to the Secretary and the State prior to the issuance of PSRO confidentiality regulations. However, the amendment fails to meet this objective in that it still prohibits disclosure prior to regulations for these purposes.

Mr. Chairman, this concludes my prepared remarks. My colleagues and I will be pleased to answer any questions you or other members of the subcommittee may have.

Mr. ROGERS. Thank you very much.

I think your statement has been most helpful and constructive.

Currently, must HEW be invited by a State in order to make inspections with respect to fraud?

Dr. MORRILL. Generally, on medicaid that has been in the program design, a State responsibility. We have as I noted in our testimony, worked with States and found them quite willing to have us. We clearly, under the law, have some authority to look at cases, though I think——

Mr. ROGERS. What has been the practice?

Mr. MORRILL. To work with the States on that matter.

Mr. ROGERS. To allow the State to invite you in before checking?

Mr. WEIKEL. So far, in three States we have initiated activities with our medicaid review terms. We have done it with the cooperation of the States, but we believe we have authority to do it even if the States chose not to cooperate.

Mr. ROGERS. What about under the proposed legislation?

Mr. MORRILL. Under the proposed legislation, the same would apply. When dealing with a State-managed program, it would seem appropriate to try and proceed in that manner, if the States are willing to cooperate, but we should still retain the authority to proceed even without them.

Mr. ROGERS. But you could go in without an invitation from the State?

Mr. MORRILL. Yes.

Mr. WEIKEL. Along that line, we believe we should have very specific authority in the legislation that we have equal access to the records that the State program would have, and that we also have authority to copy those records because that is very integral part of documenting a case against a fradulent provider.

Mr. ROGERS. How many people are now assigned to this responsibility in the Department?

Mr. MORILL. Let me give you several groupings of numbers. In the audit agency we now have approximately 1,000 people. In criminal investigation work, I think the authorization is about 74 in the central office. In addition to that, in program oversight and monitorship in medicaid, there are 119 that are committed to the fraud and abuse control area. In the case of the social security medicare program, I believe the number is about 240.

Mr. ROGERS. How many of the audit people are devoting their time to criminal prosecution for fraud?

Mr. MORRILL. The auditors—and I will let Mr. Walsh expand on this—the auditors are not, themselves, involved, but will refer a potential criminal matter to the investigators and then work with them in those instances to support their investigations.

Mr. WEIKEL. There are approximately 70 person-years, from the audit agencies, devoted to medicaid.

Mr. ROGERS. How many people would that be?

Mr. MORRILL. They tend to express that in person-year terms because it will be the way they are organized; an audit team will be working on one subject for awhile and then move to another area. But, I think to combine medicare and medicaid, it is about a 140 to 180 person-year effort going into that activity from the audit agency.

Mr. ROGERS. So you have how many teams at work?

Mr. MORRILL. We now have two specialized teams on medicaid in operation, and a third soon to begin.

Mr. ROGERS. How many in each team?

Mr. WEIKEL. Approximately 18 people on each of the medicaid examiner's teams. We have two teams that are functioning, one working in Massachusetts, one working in the State of Ohio. The third team which has just come onboard, will go to the State of Georgia beginning in October. The only positions on those teams that are not filled are the certified public accountants, and we are in the process of hiring those right now.

Mr. ROGERS. So you don't have any accountants on the team yet?

Mr. WEIKEL. No certified public accountants, except one at the present time.

Mr. ROGERS. What kind of personnel do you have? I would think that it would be critical to have a CPA.

Mr. WEIKEL. We have some lawyers and some individuals who have previously been criminal investigators. We have some individuals who are health professionals and we have some generalists. Each of these individuals has gone through a training program pertaining to medicaid and to fraud and abuse prior to being put in the field.

Mr. ROGERS. Could you let us have for the record the makeup of the teams and their names and qualifications?

Mr. WEIKEL. We can provide that.

[The information requested was not available to the subcommittee at the time of printing.]

Mr. ROGERS. You know in the clinical laboratory legislation we have put in a number of provisions to control fraud and abuse as well as to improve the quality of laboratory service. I presume the Department would be using that.

Mr. MORRILL. Yes.

Mr. WEIKEL. We do support those.

Mr. ROGERS. Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman. What do you think are the causes of medicare and medicaid abuse?

Mr. MORRILL. As I noted, Dr. Carter, in the opening statement, there are a number of factors that I think lead to it. The program design itself in many cases invites this kind of activity. In the medicaid program, the reimbursement levels in some States are so low that that tends to have the better qualified physicians not participate and, again,

invites things such as the medicaid mills. I think there are only a limited number of people who very clearly have the intent of ripping the system off.

I think in our testimony here, it should be clear that it is a small group, but one that we need to be concerned with. But all of those factors, I think, are involved. The States have not been equipped in medicaid with an adequate management information system which would allow them to do a number of oversight activities, including the detection of fraud and abuse by examining practice files and the like, for overutilization and misutilization. That is an important deficiency, one which we have been urging for some time that the States remedy, in terms of putting in these new systems. A good many of them are now moving in that direction.

Mr. CARTER. What would you estimate has been the cost of fraud and abuse in the medicare program, during the past year?

Mr. MORRILL. On the medicare side, please let me ask Mr. Tierney to respond.

Mr. TIERNEY. That is a very difficult question, Dr. Carter, and I don't mean to not answer it.

Mr. CARTER. If you can extrapolate, please try to make an educated guess.

Mr. TIERNEY. I could make this kind of educated guess. As Mr. Morrill said in his original statement, since the inception of the program, medicare has investigated some 41,000 allegations or assertions of fraud or abuse. Of that number as Mr. Morrill said further, we have investigated every single one of those. Of that number having investigated them, we finally turned over to the U.S. attorneys for prosecution 578. There were 186 convictions of fraud, 33 are pending trial. I think it is significant to note that even after all that screening the U.S. attorneys declined 164 of those cases and in 22 others the people were acquitted. So what I am trying to say, Dr. Carter, is that when you say what was the result of fraud, how much did fraud cost if you equate it to a $15 billion program, it was very, very small.

We have collected, to date, around $17 million which resulted from cases in which there had been an allegation of fraud. In those cases there was a total of $34 million involved so that is another way of saying $17 million. But I don't want to overstate that, Mr. Carter. We have not found every single case of fraud and abuse. On the other hand, I think the activity we carried on has, not unlike the IRS approach, had a great deterrent effect on fraud and abuse.

What I have to answer to you sir, is, on a sheer basis of dollar amounts identified, it has been in the neighborhood of $33 million for fraud. It could be a lot more.

Mr. CARTER. Medicare?

Mr. TIERNEY. Yes, sir.

Mr. CARTER. And what about medicaid?

Mr. MORRILL. In medicaid the first thing to be said is there is no precise way of getting a number on that. The estimates we think are——

Mr. CARTER. We see estimates in the press up to billions of dollars.

Mr. MORRILL. That clearly gets beyond what we would recognize as a valid number. On the fraud side, our estimates run in the neighborhood of 5 to 10 percent of the program cost, which translates into about $750

million to $1½ billion. From rough estimates suggested by some numbers in related fields, that we would say that is in the credible range.

Mr. CARTER. You say $750 million to $1½ billion is a credible estimate?

Mr. MORRILL. It is a credible estimate. Numbers that I have seen higher, I don't find credible.

Mr. CARTER. One of the factors you mentioned which leads to medicaid fraud is a low reimbursement level. In rural areas, we do find that medicaid payments are smaller but yet the major problems occur where the payments are greater in the metropolitan areas. We have had more evidence of fraud in our large cities than anywhere else, have we not?

Mr. MORRILL. Yes, sir, but even in some of those cities the reimbursement rates are substantially less than what is customary in the area.

Mr. CARTER. Yet you know, though, that when you get into rural areas the payments are usually less.

Mr. MORRILL. Yes, sir.

Mr. CARTER. I know my State of Kentucky is divided into three classes: large metropolitan areas which get the highest rate, a second middle classification, and the third, for mainly rural areas which receive the lowest rate of reimbursement. Rural physicians don't like this kind of classification system, and I don't blame them for it. Yet, the fraud—and I hope it doesn't turn up in my State—seems to have appeared where the larger payments are, contrary to what you have indicated.

Mr. MORRILL. Dr. Carter, if I could clarify on that. I don't mean to argue with you that the urban centers are paying higher than the rural ones. That's correct. But what is being paid in some of the urban centers under the medicaid program is substantially less than that being paid for customarily in that area for, say, an office visit. That large differential between what is customary in that area and what is paid under medicaid tends to reduce the number of physicians who will deal with medicaid clients, and encourages such things as medicaid mills.

Mr. CARTER. I notice you are conducting an investigation in Massachusetts and also one in Georgia. Have you found evidence of fraud in those areas?

Mr. MORRILL. The investigation in Massachusetts is the first and the results are just now in the process of being completed. We have not finished the first one, and the second one is underway in Ohio.

Mr. CARTER. Why haven't you centered in on New York City?

Mr. MORRILL. We expect over the course of this fiscal year, as I noted in my testimony, to reach 10 States that will account, as I recall, for about 70 percent of the total medicaid expenditures, and would include New York. In initiating this thing we started with not the largest program States but with some in the intermediate size so we could gain experience with our teams.

Mr. CARTER. Is it true in New York City 17 laboratories, or laboratory companies, do about 60 percent of the laboratory work of the State?

Mr. WEIKEL. I can't give you that figure off the top of my head. It would sound reasonable.

Mr. CARTER. I believe that is right. It doesn't seem like much competition. To me it is a tangled web of fraud, deceit, and wrongful doing. And yet it seems to me we have been delinquent in not getting

after this problem. I certainly support legislation to remedy this situation.

Mr. ROGERS. Thank you.

Mr. Scheuer.

Mr. SCHEUER. I want to emphasize my agreement with Dr. Carter. We don't agree every day of the week on everything, but I certainly support his sense of concern here. I must say, Mr. Tierney, you have a sense of complacency about this thing that I don't feel is justified by the realities of the situation. When you were asked what were the problem dimensions, you mentioned $17 million as having been involved. And you also mentioned the great deterrent effect of something. I am not sure what you feel you are presently doing that is deterring anybody, because we just heard from the Assistant Secretary that he believes there is somewhere between a 5-percent and a 10-percnt-rip-off factor involved in our current medicaid and medicare programs.

Mr. MORRILL. Medicaid.

Mr. SCHEUER. It seems to me that it is not a very small part of the profession that is involved here. It seems to me it is a fairly significant part of the profession. If you are talking about 5 to 10 percent of all charges, you are talking about growing from $1 to $5 billion. It is quite true they are difficult to identify and to quantify, but I think your estimate of three-quarters of a billion to a billion and a half is certainly on the conservative side and perhaps properly so.

The Senate took testimony that the programs are structurally designed to encourage fraud and abuse and I think you used almost those same words. You talk about fundamental reforms that are necessary. How can you say that there is only a small part of the profession involved? It seems to me there is a considerable part of the profession involved and that there are structural abuses here. I don't see any great deterrent factor at all and I am amazed at your feeling that God is in his heaven and all is really well.

Mr. TIERNEY. I would like to reply, Mr. Scheuer. I have no sense of complacency. I assume God is in his heaven but I have no feeling everything is well but I think it is a very basic thing to make a distinction. I don't make myself popular with my colleagues in the Department who are not responsible for these differentials. It is very important to distinguish between medicare and medicaid. Medicaid as we know—and I am sure you are aware—is in effect a vendor program for welfare recipients and those people who a State determines to be medically indigent and is operated and run by the States. Medicare on the other side of the fence is a Federal program administered federally.

In reply to the chairman's questions earlier—I thought that it might have been well to interrupt but I guess it wasn't—he was asking about how many people do you have working on fraud and abuses. And our answer had to be in the Bureau of Health Insurance we have 200. In the system under which medicare operates around the country I dare say there are 5,000 and that is the basic distinction. There are 28,000 people employed in the administration of medicare.

Mr. SCHEUER. You are talking just about medicare?

Mr. TIERNEY. Right.

Mr. SCHEUER. I think it is quite fair to say most of the fraud and abuse that the Senate has been investigating has been in the medicaid area.

Mr. TIERNEY. I totally agree with you. The figure may be larger but I would like to put that in a little perspective. Currently, 73 percent of all medicare claims that are submitted incur a reduction. That is the effect of having a system, Mr. Scheuer, not the effect of any personal brillance or anything else, but the programs are structured differently and therefore I think what I was saying to you was that in those cases in which we have finally turned the matter over to the Justice Department and in which they have accepted them and in which they have prosecuted, there have been a total of I said $34 million—$31 million involved in those cases of which we have been able to collect $17 million.

That is my best answer to what factually I can tell you about medicare fraud.

Mr. SCHEUER. What lessons do you have to tell us between the differences in the level of fraud in medicaid and medicare programs and the degree to which the medicaid programs seems to be structurally inviting fraud and ripoff as heard by the Moss committee?

Mr. TIERNEY. I think you are getting to the substance of it. As Mr. Morrill said to you, one of the problems with medicaid was the States decided to pay quite low fees to physicians, say in New York City. And therefore many—and I don't know what percentage—of the normal reputable physicians in New York City say, "I am sorry, I don't want to have anything to do with that program." And that therefore creates a two-level medical system where medicaid people go to the medicaid mills or some other source and the rest of the people go to another.

Medicare is not that way. We simply insure the individual. He can go to the same physician and he will get the same fee as Vice President Rockefeller does if he goes to that physician. No more, no less, but we do get away from that.

Mr. SCHEUER. You testified that the program designed for medicaid seems to encourage or perhaps even invite fraud and you talked about the reimbursement levels. Why is it that your agency, in the face of these repeated scandals over many, many months, has done so little, either in coming to us with suggestions for changes in the program design if you needed legislation, or talking with the States about producing reimbursement levels that would be sane and that would be reasonable, attractive, and acceptable to doctors and that therefore would not invite this kind of fraud?

Mr. MORRILL. Let me respond in several respects. I noted in my testimony that we have moved to do something with respect to fraud and abuse. We have also been encouraging States in a number of other areas, such as management information systems and others.

Medicaid, however, is essentially and structurally a State-based program, and for us to move in and begin to dictate reimbursement rates, for example, would raise questions as to the kinds of flexibility the States would have with respect to service and the rates at which they reimburse them.

Mr. SCHEUER. I can see that as a general matter but Grover Cleveland said a century ago, we are faced with a condition and not a theory. As a theory, yes, the Federal Government does not like to meddle around too much in State affairs when it is a State-run program, but the condition is that this is a program that just got out of hand in a bizarre way, totally out of hand, out of orbit.

It seems to me there was such egregious abuses here that you had a duty to go in there and talk with the States about coming up with an

administrative program on their part that would not make a monstrosity out of your Federal program.

Mr. WEIKEL. I am one of those individuals around the country that believes this program can be administered and the tools are available, the technology is available, to effectively administer if we put our minds to it, both Federal and State level.

I think there is a track record in the administration of medicaid over the last several years. States are becoming more interested. We have provided some leadership to them—that is a critical area, not only in fraud and abuse, but also third party recovery liability of $200 to $600 million—to emphasize needs for better management information.

I believe that the States must have an effective system for claims payment. You cannot operate any large-scale health financing program in this Nation, public or private, without routinely running patient and provider profiles which display at one spot all the services that an individual recipient is receiving, or all the services that an individual provider is prescribing under the program, and States are moving in this direction.

We have 10 states that have such a claims payment system in place, and at least 20 more are in the process of implementing it. That is a dramatic change from 2 years ago. States are increasing the number of services. You heard that I think medicare provided somewhere in the neighborhood of 30,000 to 40,000 investigations over the history of the programs. The States in fiscal year 1976 initiated over 7,000 investigations of medicaid providers only, not including recipients in that number. That compares to 1975—just 1 year ago—when we started only 2,600 investigations. So we tripled the number of investigations begun on medicaid providers in a single year.

Mr. SCHEUER. Your investigations or the States?

Mr. WEIKEL. They were both. Mainly the States.

Mr. SCHEUER. We had testimony up in New York—and you had an observer there so I am sure you are familiar with it—along two lines. First, there was not a helpful degree of communication between your office and the States in perfecting the art—let us say the state of the art—or in pointing to the current developments in the state of the art, of controling medicaid fraud and abuse.

They did feel that way.

Mr. WEIKEL. New York State may feel that. New York is not the Nation, I suggest. You are hearing from the State of Michigan this morning and you ask him that question.

Mr. SCHEUER. We also heard from the State of New Jersey along the same lines.

Mr. WEIKEL. We have had active programs in that State in the fraud and abuse area. Over the last year we developed a series of review guides to test whether physicians, pharmacists, nursing homes or clinical laboratories are actually defrauding the program. They have been field tested. They are being used by our medicaid examiners. We are in the States. We are going into the top 10 States that account for 70 percent of the dollars. We are offering to train all the States.

If they want to use these guides we are making those available to the States. On November 8 we are having a major national conference

in Dallas inviting all the State medicaid staffs in the fraud and abuse areas to train them, as well as State Attorney General's staff to train them, on getting effective prosecution. So I think something is being done.

Mr. SCHEUER. We also heard testimony from both New York and New Jersey on provider fraud and abuse. They are aware of the problem and they are aware of the extent of the problem but they do not have the funds to carry out the sophisticated and technical investigations that have to precede prosecution.

They were aware of the degree of the ripoff but they did not have the resources to go after it. In the bill that I put together with Congressman John Moss and Andrew Maguire of New Jersey, we provide for an auditor general, as well as 90 percent funding from the Federal Government with a 10-percent matching requirement on the part of the States to spend in souping up their investigative and prosecutorial staffs, their investigative and prosecutorial capabilities for getting a handle on medicaid fraud. It seems to me the payoff would be astronomical. The cost benefit factor of that investment by the Federal Government in the States would be off the chart. Would you start by providing the States with resources to beef up their investigating and prossecuting staffs.

Mr. MORRILL. We have, as I think Dr. Weikel indicated, been moving strongly. I recognize the financing issue. We do provide in some areas an additional match for activities on the management information system and on certain categories of personnel that they may hire.

They are now matching 75 percent as opposed to the customary 50. The additional costs involved in going to a 90 percent match are quite substantial.

Mr. SCHEUER. Do your programs include funding for increasing their investigative staff and prosecuting staffs?

Mr. WEIKEL. We will match anything the States want to invest in at a minimum of 50 and up to 75 percent depending on the types of people involved.

Mr. SCHEUER. That is medical personnel. How about lawyers, investigators.

Mr. MORRILL. There is a 50 percent match for the categories you just mentioned.

Mr. WEIKEL. What would your reaction be? Where the payoff is so astronomical to the Federal Government as well as the States, the savings are going to be Federal savings, taxpayers' savings.

Mr. MORRILL. We think they have inherent incentives in making those investments for the reasons you cite. The issue of whether we ought to increase those matches beyond what they are now is something that we have been exploring.

You would think matching half of the different kinds of savings would be sufficient incentive, and indeed some States have substantially beefed up. Others have not. But we are exploring that. As I say, there could be quite a substantial bill involved if one were to adopt a flat, across-the-board, 90 percent match.

Mr. SCHEUER. If you look at the States in the Northeast and Midwest corridor, they are in such financial straits that even though they know this is desirable they are incapable of doing it.

Mr. WEIKEL. In terms of the administrative match I would urge we look at the need for the total program as well, and not just the fraud and abuse investigators, because it is not only after the horse is out of the barn that we have to be concerned. We have to be concerned about the front-end management, and that is where we have to provide resources to the States as well, and we are providing some of these resources to them.

Mr. BROYHILL. I don't have time to ask my question between now and the time we go to vote. Can I defer until we go to vote.

Mr. ROGERS. Yes, but would you like to start and you will have time when we come back, too.

Mr. BROYHILL. We only have about 5 or 10 minutes to get to the floor.

Mr. ROGERS. Mr. Preyer.

Mr. PREYER. Mr. Chairman, I may not be able to come back before lunch. I will ask a couple of very quick questions. Thank you, Mr. Morrill, for a very helpful statement. You listed some of the causes of the problems here and I can agree with what you said. But isn't the basic cause also the lack of alternative service in those areas where there are many, many medicaid recipients? Don't we have to think about a basic solution to this problem of providing, through HMO's or community health service or more national health service scholarships, something to take the pressure off of the demands to set up these medicaid mills.

Mr. MORRILL. I think you are right. A combination of efforts is required and the manpower legislation, indeed, with its focus on trying to work with the under-utilized areas and move toward more primary care physicians and the like, is another part of a solution. Likewise the HMO approach and others seem to hold some promise. It is underlying all that truth, that in order to attract qualified physicians to underserved areas you are going to need to compensate them at a level commensurate with adequate income in those underserviced areas or low-income areas, and if that is not there, all the other things may not work very well. So it is a combination of activities, I think, that needs to be directed at that problem.

Mr. PREYER. I won't have time to explore this but I want to throw out two more suggestions. We need to provide some better alternative service in these areas where the abuse and the fraud takes place. These are largely the large cities where you have a heavy population that is eligible for medicaid, and a relatively small degree of service, so they turn to the medicaid mill to furnish alternative service. What do you think of the idea of taking the savings which would result from those fraud investigations and earmarking them back for alternative service in these areas rather than sending them back to the general taxpayer.

Mr. MORRILL. I have no problem with that idea in general. Indeed, to try to get better service to those clients in medicaid is, I think, an underlying objective that we have been seeking, and, indeed, it was the pursuit of that objective above all others that got us into some difficulty over the period of time where we did not pay enough attention to the management side of the house. But, clearly, using resources saved from reducing the fraud and abuse and putting that back into better service for people by a variety of techniques is something that we would welcome.

Mr. PREYER. One final comment. I think you made a very helpful distinction in your testimony between fraud and abuse. We keep lumping them together in the same sentence.

Fraud is intentional wrongdoing, but to put it in focus, the losses from 3 percent of all the doctors having a bad day and doing something wrong or unnecessary unintentionally will add up to the same amount of loss. When you have a program of this size, the figures are going to be enormous without fraud and I agree with your suggestion that the system has to be set up as well as possible. The PSRO's and what not need to work steadily at that problem on a day-to-day basis rather than a crisis situation.

I am afraid we face a crisis situation.

Mr. ROGERS. The committee will stand in recess for 5 minutes while members vote. We will try to conclude our discussions with you before noon and perhaps take one more witness before we recess for lunch.

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order, please.

Mr. Broyhill?

Mr. BROYHILL. Thank you very much. I appreciate your patience and I won't take but just a few minutes, but I did want to get into a couple of different areas of questioning, one, of course, concerning the legislation that is before us. I do understand, of course, and have been aware of the fact that the Department has set up an Office of Investigation and has been proceeding during these past several months to carry out a program of investigations of fraud and abuse in the medicare and, particularly, medicaid programs.

I also understand the administration and the Department—and, in fact, all administrations in the past that I have served under—have been reluctant to endorse bills or legislation that tend to set up administrative units by statute. Administrations and departments like to have the flexibility to do their own thing, but Congress does have an active interest in this area, as well as many other areas, particularly in this issue of doing what we can to eliminate fraud.

I think it would be helpful in this instance to lend some legislative support to what the Department is attempting to do on its own. I can understand the Department's concern over the several bills that are now being considered, over the possibility of duplication of efforts or setting up of offices that may tend to be almost competing against each other.

Perhaps you would want to comment further on that particular aspect of the legislation that is being considered not only by this committee but that has been reported by other committees, duplication, the area of divided effort, and so forth.

Mr. MORRILL. Yes, sir, and I think I can summarize that. We prefer the broader context of the inspector general bill to be an organization focused exclusively on medicaid, medicare, and health financing programs. It just makes better sense in terms of the use of our resources, of the amassing of skills necessary to do the job and, if you will, efficient organization.

You are, I think, quite right in noting that we are quite like other administrations before us in preferring some flexibility, particularly at subordinate organizations, but we recognize with respect to an overall bill that the Congress does have a hand and is partner with us in

that, and that the notion of an overall inspector general in legislation is one that we accept and endorse.

We are hoping to make the specialized unit within the inspector general concerned with the health financing programs in a way that makes organizational sense. I think language that has been discussed over the last few days makes it clear that there is not a substantial difference of view as to the substance of how that ought to be done. and it is merely finding technical language to make that possible. I am optimistic that we can do that.

Mr. BROYHILL. Let me get into another area about the bill that is before us and then I want to get into another area of questioning altogether.

When the Congress sets up these offices or sets up a new program, we would like to have some control over it to make sure what they are doing, to get information, and in this bill we provide that the inspector general or the person in charge will be reporting the information that is developed about fraud that might be prevalent, to the Congress.

Now, I note in your testimony you are concerned about this section. Why is this? Maybe I don't quite understand the real reason why the Department would be reluctant for the inspector general to be providing this information to the Congress.

Mr. MORRILL. Let me say, Mr. Broyhill, that as the bill stood in its introduced form, there is essentially two kinds of reporting to the Congress from the inspector general. One is an annual type of report that discusses the activities and so forth, and we have no problems with that.

In addition to that, there was a feature that required the inspector general to essentially immediately report what is described as "flagrant abuses" to the appropriate committees of the Congress, without much reference to the Secretary of HEW, and it was that provision, in its original form, that we found most troubling.

Both the President and the Congress, I think rightfully, hold the Secretary of HEW accountable for the performance of the programs under his jurisdiction. It seems appropriate to us that he, in turn, be the one held accountable for reporting the abuses to the Congress, rather than having the inspector general, if he found something "juicy," run off without bothering to tell the Secretary what was going on.

Mr. BROYHILL. You are not objecting to the concept, you are just objecting as to who does the reporting?

Mr. MORRILL. That is right. And we have suggested in our approach that the Secretary be the one held accountable. The letter from Mr. Fountain that the chairman read indicates that from the inspector general bill, as it now stands, Mr. Fountain is suggesting a partial solution to the problem we saw. That is, by providing a 7-day intervening period for the Secretary to become informed of what has been found and direct such appropriate action as may be required.

That, clearly, is a big step in the right direction. Our suggestion has been that the Secretary be the one held accountable for that reporting.

Mr. BROYHILL. Now let me get into another area of concern. I think my colleague from North Carolina, Mr. Preyer, has expressed some of this. I regret that, because of other appointments, he was not able

to stay and to explore some of these concerns further, but as I understand what he was approaching, with the present system that we really are not going to be able to do much to get a handle on this problem of fraud and abuse.

In other words—I don't know that he was saying it exactly this way—but what we are doing here is almost a necessity, but it is more of a band-aid approach and may be what we should be doing is exploring ways to change the system so there won't be the incentive for fraud and for abuse.

As he was speaking, I was thinning of how do you define the terms "fraud" and "abuse.' I know that this is the term that you use in the legislature. When does abuse become fraud? These are two closely related terms, it would seem to me. First, do you have a definition for the two terms, "fraud" and "abuse," and which is the larger problem?

Mr. Morrill. Let me say—without resorting to my dictionary—I will try. I think in fraud you are talking about a criminal act. That is intent on the part of, say, a provider, to rip off the system. Now "abuse" is, by contrast, a term that we apply to overutilization or misutilization of the system, improper services being rendered without any intent to defraud the system; but they are erroneous payments or activities of one kind or another, and not necessarily illegal.

It depends a bit on the individual circumstances. In the abuse area, again, we don't have precise numbers for medicaid; but we suspect that that area is indeed somewhat larger than the fraud area—that is, the estimated percentages would be larger than the ones I used earlier for fraud.

An important issue to attack, in terms of attempting to reduce abuse, is the fact that this may involve perfectly legal kinds of activities but through which funds are being spent for inappropriate purposes or for more than is required to provide good health care. That is why our testimony lays particular emphasis on dealing with more than what might be called the back end of the system, that is after some fradulent activity is underway and we are after the culprit in the case. Though all programs require that component, what you need to have in place is a system that will identify the performance of the program, what is going on, being able, as Dr. Weikel noted earlier, to identify patient profiles, provider profiles, where we can spot potential abuse to correct it. As one gets into looking at that abuse, you may find that there is indeed a fradulent attempt, and you may have to put it over on the criminal side. However, a core system is necessary for preventing and reducing, if it occurs, the abuse and the fraud.

Mr. Broyhill. You do differentiate between the two in the attack on the total problem of overpayments and so forth, and how you allocate resources.

Mr. Morrill. That is right. Within the medicaid program, as I noted earlier, there is at the Federal level about 120 people dedicated to this purpose. Of course we want additional work at the State level. In the case of medicare, some 240 people, and they are working with the performance of the system in identifying what is going on, raising questions about reimbursement.

If they discover that there is a problem involved requiring criminal investigation, that is then turned over to the investigative unit for pursuit on those grounds. The auditors, of course, are looking also at the abuse side in their audit activities. That may in some cases lead to criminal investigation for potential fraud.

Mr. BROYHILL. What you are saying is in the area of abuse that you are looking into areas that are really, you might say, problems of design of the program or areas of where the regulations, the paperwork, and so forth, can be contributing to the problem.

I am thinking also about the problem of where you see a practice of abuse of physicians prescribing or requiring, say, too many X-rays, and so forth. When does that become fraud? There is a fine line, I am sure.

Mr. MORRILL. Yes; indeed there is. Just to use an illustration: You have what is referred to as "ping-ponging", for example, or other such practices. Hopefully under these systems you can identify that as an abuse area. If you are into a set of collusive arrangements between providers and laboratories or a group of interrelated physicians who are doing this for the purpose of ripping off the system, then you have a case of fraud on your hands. You may see some of that—excessive X-rays or overprescriptions which are not fraud, but abuse practices. Those activities are the responsibilities for the State and the medicaid program managers, whereas if you get into the fradulent side, then you are dealing with criminal investigators.

There has to be close interaction between those program monitors, or so-called program integrity groups, and the administrators. As they find things that lead them to expect there is fraudulent activities, they then call on the investigative staff to get into the matter and investigate it for that possible criminal behavior.

Mr. WEIKEL. When we talk about fraud you have to be able legally to demonstrate a pattern of practice which is fraudulent over a period of time and that is significant. You can't simply send in a shopper, a sample patient if you will, and say "you did not provide the right services" or "you billed for services that you did not really provide," and get a case that is prosecutable. You must be able to demonstrate over a significant period of time a pattern of practice. Now there are some activities that I believe are clearly fraudulent, such as when you get into the areas of kickbacks or rebates. It is very easy to make a case of fraud. There are other areas when you deal with the overutilization of services where it is much more difficult to draw a very fine line, and you have to look at the pattern of practice over a period of time.

The scenario we see developing in the program is that first you have poor management, lax management, claims payment systems without controls built into them for overutilizations that are kicked out to a peer review group, either PSRO or utilization control groups in the State government that is administering the program.

When you don't have those controls built in you get overutilization of services, which then sometimes leads to providers making a conscious decision at some point, "Hey, I have a good thing here. I don't get paid rapidly, but then I put in another bill and not only do I get one check but I get two checks at some point in the future." They do that, sometimes a number of times quite innocently, and find

out they get a number of checks, and then they decided they created the perpetual money machine.

Mr. BROYHILL. What we are saying is the system that has been designed sometimes creates its own problems, and I don't know whether we get into that aspect right now, Mr. Chairman, but it seems to me that in the next Congress this committee should be looking to that very much in depth.

Mr. ROGERS. Thank you, Mr. Broyhill.

Any other questions?

Mr. CARTER. Mr. Chairman, I would like to ask the gentleman about factoring. I don't know much about it. It has recently come to my attention that some doctors sell their medicaid bills to factors. Would you explain this and tell us if there is much fraud in this area?

Mr. MORRILL. The problem that the legislation addresses is where, say, a billing agent or factor is brought in, and the factor's pay for his work is contingent upon how much he collects from his activities. That is where abusive practices grew up, and that is what the legislation as previously passed intended to stop. We agree with that.

Mr. WEIKEL. There have been some practices in some States where factors have actually taken the bills that the physician has submitted to them and changed the amount that the phyisican has billed to some higher level or in some situations created totally new bills, additional bills, that physicians had not even submitted to them.

There are cases of abuse and fraud by factoring agents.

Mr. CARTER. Do you have any way of checking up on that, to find out if they are increasing the physicians' charges?

Mr. WEIKEL. It can only be done through our investigations, through medicaid. You can also do it through the systems by looking at the pattern or practice of bills that are submitted by physicians or other providers. But you don't know at this point whether or not the physician had submitted some lower charge on the bill he sold to the factor.

Mr. CARTER. I believe in most States it is customary, when medicaid pays a bill, to send a copy of it to the patient; is that correct?

Mr. WEIKEL. That is true in medicare. In medicaid if they have the medicaid management information system totally implemented, the present legislation requires them to send that to 100 percent of the recipients.

Mr. CARTER. I remember the case of a former patient of mine, some time ago. This lady showed me a yellow slip, which was a copy of payments which had been made to another physician of hers. Referring to those charges, she said, "Doctor, I didn't go there. I was not there at that time." It was a very difficult decision for me to make but I sent her bill in with a statement reporting the discrepancy. I never heard anything more about it. As far as I know nothing was ever done.

Mr. MORRILL. What she did was precisely what the system has intended she do, and that is if she discovers that she has been billed for a service she did not receive is to let the appropriate people know that that happened, because that is clearly one of the clues that something amiss is occurring.

Mr. CARTER. I don't know whether I was the appropriate person or not. I hated to do it but I did, but I heard nothing about it after that. In medicaid, in Kentucky particularly, you furnish 75 percent of

the money in that State. The State furnishes about 25 percent. I understand it varies in other places, States where payments are larger. It seems to me you should be watching these things more closely because actually there are more Federal funds in that than the States are putting in.

Mr. TIERNEY. Dr. Carter, if I may get into that aspect of the thing. Under medicare, when a payment is made for a physician's service, we send out what is called an explanation of medical benefit form. It tells the lady, as in this case, we have paid Dr. Jones $15 for an office visit. That has proved to be the primary source of assertions or allegations of something is wrong with this, because the patient says, "I never went there," as in this case.

Now I don't know why you did not get an answer. You should have or she should have, but getting back to the thing that I was talking about previous to the recess, we are receiving and processing in medicare now about 120 million physicians' claims a year. Part B claims. Those go out and every one of them goes out then with an explanation of medical benefit. Many people, Dr. Carter, and I don't mean to impune this lady at all, but many aged people are very much confused with this thing. They say, "Gee, I never got that service." When we get into it, they got the service but maybe it is named something else.

Now when we find, however, that here is a doctor charging for something he never even rendered any service for, and as Mr. Weikel said, when we then start investigating and find, Yes, that is a kind of pattern with this guy, there you have fraud.

In answer to Mr. Broyhill's question, when a man is charging you for something he did not do, that is fraud. Now, on the other hand, the abuse aspect, which is probably more difficult, you don't have a fraudulent situation. A doctor, for example, who charges twice as much as his colleagues do, that is awful but it is not fraud. Or he gives people a lot of office visits. He says, "Come in every week," and they do, and that is what he charges for, and that is the end of that. That is not fraud. But it may very well be program abuse.

All I am getting to was on that explanation of medical benefit form, I don't know why you did not get a reply, but that is the source of our greatest pool, if you will, of investigatory activities.

Mr. CARTER. I checked the dates on that slip and asked the lady definitely. She said she was not going to the doctor at that time and did not go to him. This case was one instance in which I have seen this happen.

Mr. TIERNEY. That is what it is designed to do, to ferret out those situations so something can be done about it.

Mr. CARTER. How much factoring is there in urban areas? Do you have many physicians who sell their medicaid bills? Some say that because payments are so late it encourages doctors to do this.

Mr. WEIKEL. That is a problem. The factors we have are usually in the urban areas that we are aware of. One of the reasons for factoring is the slow payment by the program at the State level. There is no technological reason that that payment has to be slow. We certainly have encouraged the States to provide rapid payment to providers as one means of reducing the need for factoring.

Mr. CARTER. How slow are those payments?

Mr. WEIKEL. It depends on whether we are talking about a so-called clean claim, that has all the data elements required to process it, and

even then that varies. Some States are paying those within 15 days of receipt, but it varies all the way up to 3 to 4 months. Some States, on unclean claims, take significantly longer.

Mr. CARTER. Sometimes as long as 5 months?

Mr. WEIKEL. They can.

Mr. CARTER. What type of physicians take advantage of, or use, factoring?

Mr. WEIKEL. I don't think we can answer you certainly.

Mr. CARTER. All of them?

Mr. WEIKEL. Certainly not all of them. We can't give you a good profile of physicians who use factoring. I think again they would be concentrated in the urban intercity areas.

Mr. CARTER. Would you say young physicians particularly, since they are just getting started?

Mr. WEIKEL. I could not tell you what the age distribution is. They tend to be concentrated in the innercity and have a large percentage of their patients that are medicaid patients.

Mr. CARTER. Do you find that fraudulent practices are ripe in this group?

Mr. WEIKEL. Fraudulent practices are committed by factors.

Mr. CARTER. Have you found the existence of a large amount of fraudulent claims in this area?

Mr. WEIKEL. We cannot tell you that because we don't have really valid scientific estimates but we can tell you that there have been significant abuses on the part of factoring agents in some of the States where they are participating.

Mr. CARTER. I am really not that familiar with factoring. I don't know if there is any in Kentucky or not.

By the way, I want to compliment you gentlemen on your statement. I think you have been very knowledgeable, but I would like to see you get rid of these abuses. And, Mr. Chairman, if we save any money from this, I feel that it could be wisely used in providing assistance to our sick people, poor people, in ghetto and rural areas.

Mr. ROGERS. Thank you.

Mr. Tierney, as I recall, the Florida medicare program had some difficulty in getting proper data processing. Has that been worked out?

Mr. TIERNEY. Yes. They have, subject to the continuation of having put out a request for proposals to the entire data processing industry and analyzing the proposals, and they sent a request to us for approval of their moving ahead with a new data processing system. We have approved it and it is to be operational January 1, Mr. Chairman. We hope very much for—Florida has many problems, as you know.

Mr. ROGERS. I am very aware of it.

Mr. TIERNEY. One of them has been because of the tremendous workload and because of the advent of the "snowbirds"—each winter bringing with them another workload—that they simply have not been able to keep up with the data processing operation. We think this will help it.

Mr. ROGERS. Thank you for being present.

Mr. CARTER. Mr. Chairman, there is one other statement I would like to make. Every so often I get a bunch of checks from the third party payor in Kentucky. Once. I got some of those checks which scared me to death since I hadn't done the work. I sent them back to the com-

pany just as quickly as I got them. I think it was probably just an error but it is frightening to see them. It has been 12 years or more since I have done very much practice. I have done some—but I thought of entrapment the first thing.

Mr. ROGERS. Thank you so much for your presence here today. Since we have run past our time, the committee will recess until 1:30 p.m. I would ask witnesses to try to be prepared to shorten their statements as much as possible this afternoon to give us the most pertinent points. We dont' want to reduce testimony. We want what is necessary but if you could keep it as short as possible it would be helpful to the committee.

[Whereupon, at 12:35 p.m. the subcommittee recessed, to reconvene at 1:30 p.m.]

AFTER RECESS

[The subcommittee reconvened at 1:45 p.m., Hon. Paul G. Rogers, chairman, presiding.]

Mr. ROGERS. The subcommittee will come to order.

We are pleased to have as our next witness Beverlee Myers, the form redeputy commissioner for medical assistance, New York State Department of Social Services, and currently with the school of public health, University of Michigan. We welcome you back to the committee and are delighted to have your testimony. Your statement will be made a part of the record in full [see p. 81] and if you could highlight the points you think are most important.

STATEMENT OF BEVERLEE A. MYERS, LECTURER, DEPARTMENT OF MEDICAL CARE ORGANIZATION, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MICHIGAN

Ms. MYERS. Thank you, Mr. Chairman. I was asked to deal with and discuss the administrative feasibility of the proposal.

I think this morning both Mr. Preyer and Mr. Broyhill attempted to point out the distinction between fraud and abuse. I would also like to make that distinction, and refer you to your "Discursive Dictionary of Health Care," that was published by the committee which makes this distinction very clear. Fraud is a specific, objective and legal concept that is widely understood. Abuse is a nebulous, subjective, administrative concept which is subject to widely differing interpretations. It should be noted that nowhere in this legislation is abuse defined.

The uncovering, investigation and prosecution of fraud requires special investigatory and legal skills which are not usually present as part of general program management. It may well be desirable to establish specially staffed and visible offices for the control of fraud in programs like medicare and medicaid.

However, prevention and control of abuse is a basic program management problem. Abuse by providers of service exists in programs like medicare and medicaid because of complex and rigid regulations that are seldom fully understood and are thus not complied with.

It exists because of extensive paper work, low fees, long delays in payment for services rendered, large backlogs of unpaid bills, adversary attitudes on the part of harried bureaucrats, publicized lack of

management controls which tell the providers they can get away with anything, and complete lack of accountability for the expenditure of public funds, when responsibility is split between health and welfare agencies and proposed now to further fragment responsibility with professional standards review organizations—PSRO's—and a Central Office of Fraud and Abuse.

These problems of abuse will not be solved by putting teams of investigators in the field to look over the doctor's shoulder and second-guess whether a procedure is necessary or not. The problems will not be solved by removing management responsibility from program managers.

It is easy to criticize the management of these programs at the Federal, State and local levels. But these are difficult programs to administer and one does not improve their management by delegating major areas of responsibility to separate units or private organizations outside of the program manager's control.

It would seem much more appropriate and effective to assure that the resources, skills and knowledge necessary for efficient management were made available to the program managers so that they could be held accountable for preventing and controlling abuses in the program.

On factoring, I think it is desirable to control those abuses that might be associated with it. The most effective control would be to speed up claims payment. I question whether the proposal in the bill is enforceable.

Factoring is largely invisible. It would be, I think, a very expensive administrative burden to check on the arrangements every practitioner uses and to test those arrangements against the criteria of acceptability. For example, each time a practitioner endorses a check, would he have to assert that he is not turning it over to a factor? Would all or a sample of those endorsed checks have to be investigated to assure that the practitioner was not lying? If services were legally rendered and the practitioner had billed for the correct amount, from whom and on what legal basis could funds be recovered in the event a factor had been used?

In the area of disclosure of information, I think the bill is changed. My statement refers to a previous version of the bill and I think that disclosure is now probably more acceptable than it was in its previous form.

I would like to concentrate my remarks on the provisions with respect to professional standards review organizations. This legislation would broaden significantly the role and responsibility of PSRO's including charging established PSRO's with the responsibility to review the quality, appropriateness and necessity for services provided in shared health facilities and presumably in other ambulatory care settings. This is, perhaps, the most disturbing section of all in this legislation.

First, the section goes far beyond just a concern with fraud and abuse in these programs; it calls for a significant strengthening of the responsibility and authority of PSRO's generally and a corresponding weakening of the responsibility and authority of administering agencies, including State title XIX agencies.

Thus, the proposed amendment to section 1158 of the Social Security Act says that when the Secretary finds a PSRO competent, then

its reviews shall constitute the conclusive determination for purposes of payment under this act and no reviews with respect to such services, providers or practitioners shall be conducted by agencies charged with administering the programs. What is meant by "no reviews"? Does this mean that carriers under title XVIII will no longer carry out claims review?

The implications of this proposal are most important for medicaid and the States. Under present law, I believe, the interpretation is that when a PSRO indicates a hospital stay is unnecessary, then the medicaid agency is prohibited from paying the bill in whole or in part associated with that stay. However, for the vast majority of hospital stays the PSRO does not make a negative decision.

The law currently does not automatically mandate the State medicaid agency to pay all those bills without conducting any review. In fact, I doubt if the Federal Government can require that States turn over the control of their medicaid expenditures to private organizations that have no accountability to State government.

A second major concern with this section is its prematurity. PSRO's are just now getting started in the inpatient hospital sector, where at least there is general agreement on basic norms and standards, where diagnosis is a fairly reliable guide to services needed and where there is acceptance of a basic and uniform discharge data set which can be used for abstracting and subsequent analysis.

None of these exist for ambulatory care. It seems unfair to burden the PSRO's with development of all these very difficult aspects of the ambulatory field when they are just beginning to tackle the inpatient area.

In addition, not all the bugs have yet been worked out in the inpatient area with respect to data exchange between the agencies. Data exchange could be much more complex in the ambulatory care field and could cause further delays in payments to practitioners.

Finally, recent studies document that there is lack of evidence that PSRO's have been or are likely to be sufficiently productive to cover their costs. In other words, the savings in expenditures and utilization produced by PSRO type of reviews do not balance with the costs of PSRO operation in either the inpatient or outpatient area.

And this lack of productivity is very expensive. Estimates are that if PSRO's were in operation nationally and reviewing all medicare and medicaid inpatient stays, the annual expenditure would be approximately $200 million to $250 million.

Because of the nature of ambulatory care, where the cost of a PSRO type of review is between $1 and $1.50 per physician visit, the total expenditures would be much greater. Administrative reviews, for example, to uncover duplicate payments, inappropriate fees for particular services, unusual patterns of procedures such as injections, and similar kinds of claims review have proven to be much more cost effective than PSRO types of review.

Public Law 93–222, passed in 1973 as the HMO act, required the Secretary of HEW to contract for a study analyzing the cost effectiveness of various types of quality assurance programs. It may well be prudent, Mr. Chairman, to review the final results of that study before significantly expanding the responsibilities of PSRO's.

In conclusion, Mr. Chairman, I am sensitive to the fact that in the face of all the recent—but really continuing—publicity about the mismanagement, abuse and fraud in the medicare and medicaid programs, it is difficult to do nothing, and thus some action will be taken.

With respect to the provisions of S. 3801 I believe if it concentrated exclusively on fraud control it would serve a very useful purpose to put present or potentially fraudulent providers on notice that they would be found out and prosecuted. Abuse is much the larger problem, of course, but my plea now is not to throw the baby out with the bath water.

The most important immediate step that can be taken is to devote more resources and expertise to improving management review and control capability, particularly of the State title XIX agencies. As the medicaid expenditures rise so steeply, the States have powerful incentives to cooperate in this endeavor. I think there is ample evidence of this, for example, in New York with the recent passage of legislation permitting State administration and implementation of a medicaid management information system.

In conclusion I would say that I would be happy to work with the committee if and when basic reforms which are really necessary in this program are being undertaken. Thank you, Mr. Chairman.

[Mrs. Myers' prepared statement follows:]

STATEMENT OF BEVERLEE A. MYERS, LECTURER, DEPARTMENT OF MEDICAL CARE ORGANIZATION, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MICHIGAN

Mr. Chairman and Members of the Committee, I am pleased to be here at your invitation to discuss the proposed Medicare-Medicaid Anti-Fraud Act (S. 3801). When I appeared before this Committee last February, during your hearings on National Health Insurance, I was director of the Medicaid program for the State of New York. After two and a half years of frustration in trying to carry out that responsibility, I resigned in April, suggesting that the multibillion dollar New York program was mismanaged, that no one was really in charge of administering the program, and that I perceived little inclination to alter the circumstances. I think the recent report [1] from the Senate Special Committee on Aging has tended to confirm my suspicions.

I will not take up the Committee's time today by further confirming or challenging the reports about the scope and extent of the fraud problem in Medicare and Medicaid, or in discussing who is to blame for the problem. I have been asked to focus on the Bill itself and to discuss the administrative desirability and feasibility of its provisions.

FRAUD VERSUS ABUSE

The title of this bill is "The Medicare-Medicaid Anti-Fraud Act." However, most of the bill concerns itself not with fraud per se but with abuse. Too often, in the recent reports and publicity, and also in the rhetoric of the Administration fraud and abuse are discussed in the same breath as if they were synonmyous. But they are two very different concepts, as this Committee has attempted to point out. I refer, Mr. Chairman, to the excellent "Discursive Dictionary of Health Care" published in February by your Committee. There, fraud is defined as "intentional misrepresentation by either providers or consumers to obtain services, obtain payment for services, or claim program eligibility * * * Fraud is illegal and carries a penalty when proven."

On the other hand, abuse is defined as "improper or excessive use of program benefits, resources or services by either providers or consumers. Abuse can occur intentionally or unintentionally, when services are used which are excessive or unnecessary; which are not the appropriate treatment for the patient's condi-

[1] *Fraud and Abuse Among Practitioners Participating in the Medicaid Program*, a Staff Report prepared for the Subcommittee on Long Term Care of the Special Committee on Aging, U.S. Senate, August 1976.

tion; when cheaper treatment would be as effective; or when billing or charging does not conform to requirements. It should be distinguished from fraud, in which deliberate deceit is used by providers or consumers to obtain payment for services which were not actually delivered or received, or to claim program eligibility. Abuse is not necessarily either intentional or illegal."

Thus, while fraud is a specific, objective, and legal concept that is widely understood, abuse is a nebulous, subjective, administrative concept which is subject to widely differing interpretations. It should be noted that nowhere in this legislation is abuse defined.

The uncovering, investigation, and prosecution of fraud requires special investigatory and legal skills, which are not usually present as part of general program management. It may well be desirable to establish specially staffed and visible offices for the control of fraud in programs like Medicare and Medicaid.

However, prevention and control of abuse is a basic program management problem. Abuse by providers of service exists in programs like Medicare and medicaid because of complex and rigid regulations that are seldom fully understood and are thus not complied with. It exists because of extensive paperwork, low fees, long delays in payment for services rendered, large backlogs of unpaid bills, adversary attitudes on the part of harried bureaucrats, publicized lack of management controls which tell the providers they can get away with anything, and complete lack of accountability for the expenditure of public funds, when responsibility is split between health and welfare agencies and proposed now to further fragment responsibility with Professional Standards Review Organizations (PSRO's) and a Central Office of Fraud and Abuse.

These problems of abuse will not be solved by putting teams of investigators in the field to look over the doctor's shoulder and second guess whether a procedure is necessary or not. The problem will not be solved by removing management responsibility from program managers. It is easy to criticize the management of these programs at the Federal, State and local levels. But these are difficult programs to administer, and one does not improve their management by delegating major areas of responsibility to separate units or private organizations outside of the program manager's control. It would seem much more appropriate and effective to assure that the resources, skills, and knowledge necessary for efficient management were made available to the program managers so that they could be held accountable for preventing and controlling abuses in the program.

Therefore, Mr. Chairman, in my opinion while a Central Office of Fraud Control within the Department of Health, Education and Welfare would seem appropriate, I would strongly advise against giving it responsibility for "initiating and conducting investigations with respect to alleged, actual, or potential * * * abuse." This would be such a broad and ill-defined delegation of program responsibility that it would create massive and unnecessary duplication of staff and management activities in the Department.

FACTORING

Section 3 of the Bill is directed at eliminating the practice of factoring, which is prevalent in those programs where there are lengthy delays in payment of bills. Since factoring can lead to abuses it seems desirable to control it. The most effective control, of course, would be to speed up payments.

HEW issued regulations earlier this month designed to control factoring, and as reported by the New York Times on September 17, the factoring firms have already sought an injunction to prevent its enforcement.

Regardless of the outcome in the courts, it is questionable whether the provisions of this bill, or for that matter of the proposed HEW regulations, can be enforced. Factoring tends to be invisible to the third party payor. It would seem to be an enormous administrative burden to check on the arrangements each practitioner uses, and to test those arrangements against the criteria for acceptability. Each time a practitioner endorses a check would he have to assert that he is not turning it over to a factor? Would all or a sample of those endorsed checks have to be investigated to assure that the practitioner was not lying? If services were legally rendered and the practitioner had billed for the correct amount, from whom and on what legal basis could funds be recovered in the event a factor had been used?

On this point, it is important to recognize the difference between Medicare and Medicaid. If an audit of the Medicare program were to uncover that a certain amount of funds had been paid to factoring firms instead of directly to practitioners, the carrier responsible for permitting the practice would not be

penalized by having to absorb the costs of the mispayments. Whatever was not subsequently recovered from the practitioner or factor would be absorbed by the Federal treasury. However, if an audit of a State Medicaid program were to uncover the same thing, the state would be penalized by the withholding of the Federal matching amount, whether or not any funds had been recovered.

In summary, it seems to me that this provision is not enforceable, and the effect of it would be further to penalize states like New York that do not yet have effective claims payment systems that can prevent the factoring practice. P.L. 92-603 added provisions aimed at controlling factoring, and the recent HEW regulations are designed to implement that law. Rather than placing another unenforceable law on the books, it might be more appropriate to wait and see the results of the court decisions on the regulations and/or the efforts of States to implement them.

DISCLOSURE OF INFORMATION

Section 4 of the Bill calls for disclosure, on request, of information about ownership and financial arrangements of providers and suppliers of services, including shared health facilities. This, together with requirements for contractual agreements with suppliers and laboratories, is designed to get at the problem of kickback and rebate arrangements. While the disclosure of information is only on request of the Secretary or the Comptroller, and one supposes that such requests would be made only on some evidence of a problem, the fact remains that the potential detail of the information requested could prove extremely burdensome, particularly when required within a period of only 60 days. More importantly, it is not unlikely that the threat of having to disclose all of this information, may force legitimate providers out of the Medicare and Medicaid programs.

If this section, in its present or modified form is retained in the Bill, it would seem appropriate to include the appropriate State Title XIX agency among those agencies that may request the information (1132(a)(1)), and also to require the Secretary to notify the Title XIX agency when payment will be denied to a provider (1132(a)(2)(A)(i)).

The definition included in this section of a shared health facility is fashioned after the definition that was proposed by the various agencies in New York, following much discussion and attempts to avoid including the normal practitioner's office, medical arts buildings, group practices, etc. The definition is probably as good as can be fashioned at this time. In the context of this bill, shared health facilities are referenced in two ways: (1) placing them among those arrangements that must disclose information on request, and (2) designating them as targets for PSRO's.

Shared health facilities would be the only entity required to disclose information that does not have a direct relationship with either Medicare or Medicaid, i.e., shared health facilities do not enter into agreements with HEW, do not receive payments directly, and, according to section 3, could not receive payments indirectly. I am not a lawyer, but I do have trouble understanding on what basis the government would have the right to request information of such an entity.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Section 6 would broaden significantly the role and responsibility of PSRO's, including charging established PSRO's with the responsibility to review the quality, appropriateness and necessity for services provided in shared health facilities, and presumably in other ambulatory care settings. This is, perhaps, the most disturbing section of all in this legislation.

First, the section goes far beyond just a concern with fraud and abuse in these programs—it calls for a significant strengthening of the responsibility and authority of PSRO's generally, and a corresponding weakening of the responsibility and authority of administering agencies, including state Title XIX agencies. Thus, the proposed amendment to section 1158 of the Social Security Act says that when the Secretary finds a PSRO "competent", then its ". . . reviews shall constitute the conclusive determination . . . for purposes of payment under this Act, and no reviews with respect to such services, providers, or practitioners shall be conducted by agencies . . ." charged with administering the programs. What is meant by "no reviews"? Does this mean that carriers under Title XVIII will no longer carry out claims review?

The implications of this proposal are most important for Medicaid and the States. Under present law, I believe the interpretation is that when a PSRO

indicates a hospital stay is unnecessary, then the Medicaid agency is prohibited from paying the bill in whole or in part associated with that stay. However, for the vast majority of hospital stays the PSRO does not make a negative decision. The law currently does not automatically mandate the State Medicaid agency to pay all those bills without conducting any review. In fact, I doubt if the Federal government can require that States turn over the control of their Medicaid expenditures to private organizations that have no accountability to State government.

Perhaps the real intent here is to prevent Federal payment for the administrative costs of conducting reviews by two agencies. But, again, the problem is in definition of what constitutes the review, and in any case, there will always be some duplication of data among the agencies. Also, of some concern is the Catch 22 situation this provision creates. State Title XIX agencies that develop and install the Medicaid Management Information System (MMIS) are required as part of that system to operate a Surveillance and Utilization Review Module (SUR) in order to qualify for the increased Federal matching of administrative costs. Will they now be required to develop it but not run it?

A second major concern with this section is its prematurity. PSRO's are just now getting started in the inpatient hospital sector, where at least there is general agreement on basic norms and standards, where diagnosis is a fairly reliable guide to services needed, and where there is acceptance of a basic and uniform discharge data set which can be used for abstracting and subsequent analysis. None of these exist for ambulatory care. It seems unfair to burden the PSRO's with development of all these very difficult aspects of the ambulatory field, when they are just beginning to tackle the inpatient area. In addition, not all the bugs have yet been worked out in the inpatient area with respect to data exchange between the agencies. Data exchange could be much more complex in the ambulatory care field, and could cause further delays in payments to practitioners.

Finally, recent studies document that there is lack of evidence that PSRO's have been, or are likely to be, sufficiently productive to cover their costs. In other words, the savings in expenditures and utilization produced by PSRO type of reviews do not balance with the costs of PSRO operation, in either the inpatient or outpatient area. And this lack of productivity is very expensive. Estimates are that if PSRO's were in operation nationally, and reviewing all Medicare and Medicaid inpatient stays, the annual expenditure would be approximately $200–$250 million. Because of the nature of ambulatory care, where the cost of a PSRO type of review is between $1.00–$1.50 per physician visit, the total expenditures would be much greater. Administrative reviews, for example, to uncover duplicate payments, inappropriate fees for particular services, unusual patterns of procedures such as injections, and similar kinds of claims review have proven to be much more cost-effective than PSRO types of review.

P.L. 93–222, passed in 1973 as the HMO Act, required the Secretary of HEW to contract for a study analyzing the cost-effectiveness of various types of quality assurance programs. It may well be prudent, Mr. Chairman, to review the final results of that study before significantly expanding the responsibilities of PSRO's.

CONCLUSION

In conclusion, Mr. Chairman, I am sensitive to the fact that in the face of all the recent—but really continuing—publicity about the mismanagement, abuse and fraud in the Medicare and Medicaid programs it is difficult to do nothing, and thus some action will be taken.

With respect to the provisions of S. 3801, I believe if it concentrated exclusively on fraud control, it would serve a very useful purpose to put present or potentially fraudulent providers on notice that they would be found out and prosecuted. Abuse is much the larger problem, of course, but my plea now is not to throw the baby out with the bathwater. The most important immediate step that can be taken is to devote more resources and expertise to improving management review and control capability, particularly of the State Title XIX agencies. As the Medicaid expenditures rise so steeply, the States have powerful incentives to cooperate in this endeavor. I think there is ample evidence of this, for example, in New York with the recent passage of legislation permitting State administration and implementation of an MMIS system.

When Senator Talmadge introduced this legislation on September 10, he commented that S. 3801 was only a beginning, and that "truly basic reforms are re-

quired." I agree wholeheartedly, and at a more appropriate time would like to work with your staff in suggesting some of those reforms.

Thank you.

Mr. ROGERS. Thank you for your very helpful suggestions and we will call upon you to help us as we proceed into additional areas.

Now, you speak of improving the management techniques. What are you thinking of? How does management get to this problem of abuse? How do you find out about it and how is it really followed? How do you really know if quality care is being given?

Ms. MYERS. I was speaking in terms of the kinds of things which cause the abuse, which are slow payments, too much paper work, rigid regulations which people cannot understand and therefore cannot comply with, low fees, lack of controls in terms of reviewing the claims which come in. These are all things which can be built into the system, the medicaid management information system.

The computerized approach is, I think, the beginning step. Unless you have that kind of a system, you don't develop profiles, you don't develop the ability to look at what the patterns of practice are.

Mr. ROGERS. I guess this has been possible but States haven't responded to it.

Ms. MYERS. That is correct. In New York, for example, the problem was that medicaid was administered through 58 local agencies and, until there was legislation, they could not do this at the State level.

Mr. ROGERS. Thank you so much. Your testimony has been most helpful.

There is another call. I see this is going to be a difficult afternoon for people. So, if you will bear with us patiently, we will try to move as rapidly as possible.

Dr. John Bussman, who is president of American Association of Professional Standards, will testify next. Doctor, you might as well take the stand. We will recess for 5 minutes now and then we will begin your testimony as soon as we return.

The subcommittee is in recess for 5 minutes.

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order.

The next witness is Dr. Bussman, and you may proceed as you desire.

STATEMENT OF JOHN W. BUSSMAN, M.D., PRESIDENT, AMERICAN ASSOCIATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS, ACCOMPANIED BY WILLIAM FULLERTON, WASHINGTON REPRESENTATIVE

Dr. BUSSMAN. Thank you, Mr. Chairman.

My name is Dr. John Bussman. I am a physician in the private practice of medicine in Portland, Oreg., and the president of the American Association of Professional Standards Review Organizations. With me today is our Washington representative, Mr. William Fullerton.

Mr. ROGERS. We welcome Mr. Fullerton. We have known Mr. Fullerton for many years and know of the good work he has done. We are pleased to see you.

Dr. BUSSMAN. Our membership now includes 129 organizations. More than 110,000 physicians are direct members of our organization or are members of our PSRO constituent organizations.

I appreciate this opportunity to present our views on the PSRO provisions of H.R. 12961 as passed by the Senate on September 20.

First, we support the general thrust of the bill. It is an obvious and appropriate response to the information developed by the Committee on Aging in the Senate and by other committees in the Congress. The bill is designed to provide additional legislative tools to combat the fraud and abuse now existing in the medicaid program and, to a lesser extent, in the medicare program. It is our view that only effective administration of existing law and these new provisions will yield substantial results. And I believe that it is generally recognized that more basic reforms of the medicaid and medicare programs are still required.

Having made this general observation, I would like now to comment on the PSRO provisions in the Senate-passed bill.

We support the specific provisions in H.R. 12691 as it passed in the Senate. The primary provision in this section of the bill would require the Secretary of Health, Education and Welfare to give priority to the request of a PSRO to review the medical necessity and quality of the care provided in the so-called medicaid mills—defined as "shared health facilities" in the bill.

As you know, Mr. Chairman, present law permits the Secretary to approve a PSRO request to move from reviewing institutional care, required under present law, to reviewing other health care services, including ambulatory care services. Several of our members now perform ambulatory care review in our private review programs and several PSRO's, with HEW approval, will begin ambulatory care review within the next few weeks.

Although we have not been able to discuss this provision with each of our member organizations, it is anticipated that in the very near future only a small number of PSRO's will be ready to move to the review of these medicaid mills. However, we do pledge to the Congress that if this legislation should become law, we will move as rapidly as possible consistent with establishing an effective review mechanism.

Some action will start almost immediately. The New York PSRO, in whose area there are a concentration of the medicaid mills, has indicated that it will request the Secretary for approval to begin review shortly after enactment of this legislation. They are now preparing specific plans on how to undertake such review.

It must be clearly understood, Mr. Chairman, that this will be a complex and difficult task. Some of these places are so bad and so lacking in records, according to the Committee on Aging report, that review will be extremely difficult.

As the report of the Committee on Finance put it, "The committee is well-aware that in asking PSRO's to offer their review services with respect to these facilities, it is asking for a difficult task to be performed."

It may well be that in the course of examining these facilities, the PSRO will find that it must recommend to the Secretary, under provisions in current law, that some of them be excluded from the medicare and medicaid programs.

Mr. Chairman, the balance of the PSRO provisions in the bill are designed essentially to provide additional support for carrying out this difficult task.

The first of these would conform the funding arrangements between hospitals and PSRO's so that hospital outpatient services would be

handled in the same manner as inpatient services. The effect of this change would be to remove any financial disincentive for a PSRO to review outpatient services using its own personnel rather than delegating the review to a hospital.

Second, if the Secretary found that a PSRO was doing an effective job with respect to reviewing specified services then no other review mechanism would be permitted to operate with respect to those services and certain existing certifications would not be required.

Third, each PSRO would be required to furnish data to Federal and State agencies, at their request and within existing limitations on confidentiality, which would assist such agencies in detecting and investigating fraud.

Fourth, PSRO activity in the review of medicaid programs could not be delayed because the State did not provide its share of the necessary operating funds.

Fifth, the Secretary would be required to pay the costs of defending a suit brought against a PSRO, its members, employees, or professional consultants related to the performance of any duty or function required under the law. We are simply not afraid of retaining ultimate responsibility for our actions, but if, as I expect may happen, some of these medicaid mills file legal actions against us, we must have protection against the legal costs of defending ourselves.

In this connection, I should point out two things. First, carriers and intermediaries under the medicare program are completely protected against suits for their medicare work—the Government actually steps in and assumes the burden of defense and the liability risks.

Second, although most of the PSRO's conducting review activities are now protected for liability through a private insurance carrier, if that protection were to be lost, we would encounter great difficulty in obtaining new coverage. So far, we have not had a single suit filed.

However, even a handful of suits which we would have to defend may jeopardize our ability to obtain insurance. We need this back-up protection where we review the care furnished patients paid for with public funds.

Mr. Chairman, I would like to comment in response to some of the comments made by the previous witnesses. We, too, share the concerns expressed by the witnesses this morning representing the Department of HEW concerning the readiness of PSRO's to participate in this type of ambulatory review and as I see it, we really are talking about two different levels of review.

The first is the ability of the PSRO to identify problems not previously recognized by others, and this would require a considerable volume of data to be made available to PSRO review activities and, second, I think the primary thrust of the legislation was that the PSRO would serve as an investigative team once a problem were identified to it through the action of the fiscal intermediaries or the State medicaid agencies.

I just would like to add a couple to the potentials for abuse that have not been mentioned. I think we all have to recognize that some of these are initiated by physicians who recognize that all of these services are not strictly necessary and will sometimes be induced to accommodate a patient just in order to retain a satisfactory relationship with him. Also defensive medicine related to malpractice prob-

lems certainly lead to some of the abuses, some of the overutilization of laboratory and X-ray services that are not strictly required by the clinical state of the patient.

The previous witness talked about the removal of review responsibility from other organizations once the PSRO has been demonstrated to be capable. This is nothing new. In the present regulations it is anticipated that during the conditional phase of PSRO operations, the medicare fiscal intermediary will review a 20-percent sample of the patients, but at the time that the PSRO is designated as fully operational—none of them have been to date—this requirement for review by the fiscal intermediary would be removed.

I would have to take strong exception to the statement that PSRO's have not been demonstrated to be cost effective. In our own community we have demonstrated a cost effectiveness ratio of approximately 7 to 1. I am sorry, I did not realize this topic was going to be discussed here and did not bring documentation that we have available.

As witness to the cost effectiveness of our program, we are now reviewing all the patients for the Blue Shield program in our community and Blue Cross, which is the fiscal intermediary, has chosen to select us to do review of their private patients. And this is, of course, a strong demonstration of their anticipation that we are cost effective.

There is no constraint upon them to participate if they did not feel it was a cost effective program.

Testimony was submitted to this committee earlier this year by Don Derry, of Colorado, and Dr. Ken Platt, and I would like to refer you to that. I could only say in rebuttal to the previous witness, if the State administrative mechanisms under medicaid have demonstrated an ability to be effective, why haven't they?

I would like to have permission to submit some of the documentation that we have available but have not brought here, into the record.

Mr. CARTER [presiding]. That permission will be granted.

[Testimony resumes on p. 105.]

[The following information was received for the record:]

Dear Mr. Chairman: During the public hearing on September 22, 1976, on the medicare-medicaid anti-fraud bill, I asked for and received permission to submit materials for the record related to the allegations made by the witness who testified just before I did, Ms. Beverlee Myers, former Deputy Commissioner for Medical Assistance for New York State and now at the School of Public Health at the University of Michigan.

I believe I responded to most of her unsupported allegations during the hearing. Of course, I do not agree with her statement that the PSRO organizations have not and could not be cost effective. We believe that PSRO organizations are and will be cost effective and there are many of us who are working hard to accomplish that result.

It is, of course, too early to judge with precision what the results will be with the many PSRO organizations which have just recently begun review activities; but where such activities have been carried on long enough to make an effective evaluation, the results are positive. The enclosures to this letter, which we would also ask be made a part of the hearing record, present some of this information.

Ms. Myers also made a statement that ambulatory care review would add more than a dollar in costs to each physician's bill. Such a statement indicates a complete lack of understanding of the ambulatory care review process. The primary system of review of inpatient hospital services uses concurrent review, under which the review of the necessity of admission and continued length of stay is made in the hospital as patients are cared for. This is not the system used in ambulatory care review. Ambulatory care review is retrospective, involves the use of profile analyses of physicians, patients, and other providers, and simply does not cost anywhere near the amounts indicated by witness Myers.

I very much appreciate your courtesies to me as a witness; I was most impressed by your handling of a complex hearing held under difficult circumstances.

Sincerely,

JOHN W. BUSSMAN, M.D.

[Excerpt from report of first year of operation, Sept. 1, 1973, through Aug. 31, 1974]

REDWOOD HEALTH FOUNDATIONS (RHF), A JOINT VENTURE OF FOUNDATION FOR MEDICAL CARE OF SONOMA COUNTY, FOUNDATION FOR MEDICAL CARE OF MENDOCINO AND LAKE COUNTIES, OPERATING A DEMONSTRATION PROJECT UNDER A PILOT PREPAID PROGRAM CONTRACT WITH STATE DEPARTMENT OF HEALTH (DOH)

INTRODUCTION

From September 1, 1969 to August 31, 1971 the Foundation for Medical Care of Sonoma County and the Foundation for Medical Care of Mendocino-Lake County, in partnership with Pacific National Life Assurance Company, operated the first prepaid health plan for recipients of Medicaid in the United States. Factually, the State bought from Pacific National Life Assurance Company, an insurance policy on each Medicaid recipient and then contracted with the two Foundations to operate and monitor this program which was based on a fee for service with the two Foundations monitoring utilization, cost containment and quality of care. That innovative and pioneering project was eminently successful for its first 18 months, but during its last 6 months encountered many difficulties because of reforms being carried out in the Medi-Cal program and was discontinued August 31, 1971.

However, the successful experience in that pioneering effort encouraged the two Foundations to again enter into negotiations with the Department of Health of the State of California for a new prepaid health program under provisions of the Waxman-Duffy Act. The two Foundations decided to make their project a demonstration or pilot program with a negative or automatic enrollment of all beneficiaries of Public Assistance in the three-county area, rather than to enter into an active marketing program for enrollment of the beneficiaries residing in the area. The reason for selecting this course are explained in the presentation.

The two Foundations also decided that rather than involve an insurance company as a co-partner, they would ask the non-institutional providers of health care to become the participants in the risk sharing aspects. As in the original project, the State bought a health insurance policy for each recipient and the program operated on a fee for service basis.

Negotiations between representatives of the two Foundations and the Department of Health of the State of California occupied approximately a year's time during which the necessary actuarial studies were carried out to determine the true costs of care per beneficiary per category of aid and to determine how the project could be operated in such a manner as to represent a savings to the State of California in expenditures for medical benefits for the recipients of Public Assistance in the demonstration area.

In June 1973 an agreement was reached between all parties on all aspects of this demonstration project and a contract was signed with a starting date of September 1, 1973 for a twelve month period ending August 31, 1974. This contract has been extended on several occasions by amendments and will terminate June 30, 1975. The new contract, beginning July 1, 1975, while basically similar to the one now in operation, will include in it coverage at risk not only the Public Assistance beneficiaries but also the beneficiary in the Medically Needy Only group.

The document which follows outlines in detail all of the aspects of the operation of this demonstration project. It is believed that it demonstrates that a project of this kind is a feasible one for insuring the costs of medical care for those individuals who must look to governmental assistance for paying the costs of their medical care; i.e., Medicare—Medicaid—Champus.

It is to be stressed that this project has operated on a fee for service basis with the beneficiary having total freedom of choice of his provider of health care in or out of the area of the demonstration project.

It is the belief of the individuals who have been responsible for the operation of this demonstration project; Physicians, Hospital Administrators, Skilled

Nursing Facility Administrators, Pharmacists, podiatrists and psychologists, that if the government purchases a health insurance program from provider groups at risk under the proper conditions that the costs of care can be reduced and the quality of care improved.

The unique features of this demonstration project were its blanket enrollment of all recipients in the demonstration area, total assumption of risk by the non-instituitonal provider group, total freedom of choice by the beneficiary of provider of health care in or out of the area without any requirement of prior authorization except for institutionalization, peer review, quality of health care evaluation, cost containment and fee for service.

The reader is urged to peruse the materials carefully and evaluate for himself what has been accomplished and to consider how this demonstration can be extended and expanded to cover the health care needs and the costs of care for those individuals for whom it is the responsibility of government to furnish and pay for their costs of health care.

Finally, the Department of Health of the State of California has been completely cooperative and has done everything possible to assist in the direction of this project so that first it could come into being, and secondly that it would be a success. Those individuals from the provider group of the two Foundations who constituted the negotiating team have only the highest of praise for those individuals who represented the State throughout both the negotiations and the operation of this program.

* * * * * * *

V. UTILIZATION CONTROL

Two basic utilization control mechanisms were employed by RHF, the Coordinated Care Organization (COCO) for evaluating institutional care and Peer Review Committees for each of the several groups of providers.

A. Coordinated Care Organization (COCO)

This was established as a unit within RHF with its own administrator and a group of Nurse Coordinators. Using a set of guidelines and criteria prepared by physicians and approved by the Management Committee, it had the responsibility for evaluating the necessity for admission and the proper length of stay for patients admitted to an institution. Certification by COCO of such necessity guaranteed the institution payment for services.

The Nurse Coordinators secured from the Admitting Office the names of patients under the RHF program who had been or were to be admitted to the institution. She evaluated the necessity for such admission and, where such was demonstrated, assigned a length of stay. Prior to the expiration of the assigned length of stay, the case was again evaluated to determine whether or not an extension was indicated. A more detailed description of the program is in the Appendix.

COCO worked closely with family and physician to place the patient at the proper level of care, be it the acute hospital, Skilled Nursing Facility or home. It did not require preparation of any forms or applications by either physicians or hospitals. The only time a hospital or physician became involved in administrative details occurred when, in the opinion of the Nurse Coordinator, either a patient was admitted without apparent medical necessity or the physician requested what she regarded as an unnecessary extension of stay. Under these conditions the Nurse Coordinator contacted a physician advisor, a member of the Hospital Utilization Review Committee. He was apprised of all of the facts by the Nurse Coordinator and then conducted his own investigation, conferred with the attending physician, and made the decision as to whether or not to continue the certification of need for stay in the facility. A proper and prompt appeals mechanism for all adverse decisions was available.

The COCO program reduced the average length of stay by approximately one-half day as compared to the length of stay when this area was under State operation.

Out-of-area institutions, acute hospitals or Skilled Nursing Facilities made direct contact with COCO for authorization for admissions or extensions of stay.

Only minor problems were encountered in this aspect of utilization control. Institutions, Physicians and the project were relieved of much administrative detail and paperwork. Of utmost importance to the institution was the fact that the hospital was guaranteed payment whenever the patient was properly certified, thus eliminating retrospective denials for care rendered.

Through reports submitted by the Nurse Coordinators, it is now possible to initiate a medical audit and begin a review of quality of care. This is still in its preliminary phase. In the Appendix are examples of the early phases of this type of medical care evaluation and quality assessment.

The administrative cost of this portion of the project was more than offset by the reduction in length of stay and the elimination of prior authorization, medical consultants and paperwork.

B. Peer review

Each provider group established its own Peer Review Committee and provided to the claims examiners criteria for evaluation of claims received so that properly selected claims could be rejected and sent to the proper Peer Review Committee for evaluation.

1. Peer review of physicians' claims has been in operation in this area for many years and was simply expanded to include this program. Claims rejected by the claims examiner under criteria established by the committee were reviewed on a daily basis for the following action:

(*a*) Approved as submitted and processed for payment.

(*b*) Those services considered as over-utilization or not medically necessary were deleted and the claim returned for payment as corrected.

(*c*) A letter written to the physician requesting additional information which, when received, was then reviewed in conjunction with the claim and the appropriate decision made.

(*d*) Referral of the claim to another member of the Peer Review Committee for consultation and opinion before action on the claim.

(*e*) The claim referred to the entire Peer Review Committee at its monthly meeting for evaluation and decision.

A proper and prompt appeals mechanism was available to physicians.

From the practical standpoint, the elimination of prior authorization for more than two visits per month per physician, permitted the deletion of medically unnecessary services which would not have been possible had the provider applied for and received authorization for such services.

2. A Drug Utilization Review program was established by the pharmacists. They worked closely with physicians in evaluating drug therapy and prescription practices. In the Appendix are several of their reports and a summary of their activities.

This peer review committee led to a reduction in the number of prescriptions by making both pharmacists and physicians aware of the fact that in many instances small quantities were being prescribed repeatedly when one prescription was indicated for a longer period of time. They also noted varying degrees of incompatibility of prescriptions. They also identified a group of drug abusers. A full evaluation of this committee's work is underway.

3. The other provider groups; podiatrists, hospitals and Skilled Nursing Facilities, had their own utilization review teams and reviewed certain claims referred to them by clerks.

One of the important tasks of all of the Peer Review Committees, in addition to utilization control, was the evaluation of quality of care. As best possible, every effort was made to determine when there was underutilization or when the quality of care did not meet general standards. When such was noted, it was called to the attention of the particular provider.

C. Summary

This demonstration project has shown that the institution of utilization control mechanisms and peer review at the local level by providers who are at risk is an effective mechanism for both control of utilization and cost and for the evaluation of the quality of health care.

COLORADO FOUNDATION FOR MEDICAL CARE
TECHNICAL SUPPORT & INFORMATION DEPARTMENT
Health Care Data Analysis Division

MEMORANDUM REPORT

Summary of Federal Review Effectiveness Studies

The Colorado Foundation for Medical Care (CFMC) has been performing medical review for both Federal and non-Federal patients since 1972. While many of our programs are in their infancy, some have been in existence long enough to have acquired data that help evaluate our effect on cost and quality assurance of care.

The Colorado Foundation has been involved in PSRO activity since August, 1973, first as a PSRO prototype under a grant from Health Education and Welfare's (HEW) Bureau of Health Insurance and lately under contract from the Bureau of Quality Assurance (BQA) of HEW. Our scope of activity in this program is largely the review of inpatient services provided to Medicare, Medicaid and Title V patients in over 90 hospitals in the State of Colorado. This activity, called the Colorado Admissions Program (CAP) performs admission and continued stay reviews for medical necessity and quality of care during the patient's stay in the hospital and a retrospective look at the patient's quality of care after discharge. During the period from August, 1973 through December, 1975 we received over 265,000 admissions in 95 general hospitals. Our initial studies for this period using baseline data extending back to 1970 show a 9.5% decrease in the ratio of patient days utilized per eligible for both the Medicare and Medicaid population in Colorado. Using fairly conservative figures for the cost of hospitalization in these programs, this drop in utilization amounts to a decreased Federal expenditure of over 7.5 million dollars in these programs or about four times the cost of the review program itself. Now there are many factors outside of medical review that influence hospital utilization such as national and local trends in the economy, changing treatment modalities and changes in eligibility and benefit regulations. In addition, a trend drawn over a two-year operational period, particularly when part of one year is still measuring program startup, is admittedly short. These numbers, however, do reflect a change in utilization patterns that co-exist with the implementation of the program. If the numbers stand up to further scrutiny, and the test of comparison with numbers generated from our 1976 and 1977 experience, we will be able to say that this program is indeed cost effective.

In addition to the review of Federal patients the same CAP inpatient review program has been used experimentally in one large Denver hospital for private patients. The reaction of the self-insured company who supports this review has been quite favorable. We are currently conducting a study, similar to the one done for Federal patients, to measure the cost effectiveness of this program for private patients.

Other Colorado Foundation programs include medical review for ambulatory private and Federal patients and an extensive study in the type of review that would be effective in long-term care institutions. The ambulatory review program for private patients (care paid by private carriers and self-insured organizations) has shown to be cost effective as well, with the cost benefits to the payor approaching twice the cost of the review program.

TSID:HCDA
Ref.: 76-03A
SIMMONS/ms
August 17, 1976

MEMORANDUM REPORT - Summary of Federal Review
Effectiveness Studies (continued)

The difficulty in the measurement of cost effectiveness is dwarfed when compared to the measurement of quality of care. The Colorado Foundation has adapted the position that a medical review program, using physician generated criteria to identify questionable quality of care for in-depth review by a peer, cannot decrease the quality of care. In a 1977 modification of the information system presently used for evaluating CAP in both Federal and non-Federal sectors, we plan to measure the effect of this review program on quality of care by generating physician and patient profiles in which the actual pattern of care given is compared to a standard of care generated by a committee of physicians. One such profile done on an experimental basis has already shown that the quality of care in one hospital improved after corrective action was taken by the Foundation.

In summary, the inpatient and ambulatory review programs of the Colorado Foundation appear to be moving in the direction for which they were designed. Time and more experience will determine if that movement is real and how far it has gone.

78-675 O - 76 - 7

TECHNICAL SUPPORT AND INFORMATION DEPARTMENT

Health Care Data Analysis

MEMORANDUM REPORT

ANALYSIS OF DATA PREPARED FOR PRESENTATION TO THE HOUSE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT - FEBRUARY 18, 1976

Limitations of the Data

The raw data supplied by the Office of Research and Statistics (HEW) and used in our calculations of utilization rates (patient days and dollars), were given by telephone without verification, checking against hash totals or written followup. These data are forwarded to HEW by the fiscal intermediaries (F.I.) based on a 20% sample of all claims paid and are used in projections displayed in a report titled Medicare Analysis of Days of Care (MADOC). Generally, the MADOC projections have proven reliable; however, it should be recognized that the data supplied for a given time period by the F.I., is based on claims paid in that time period and not necessarily patient services delivered during that same period.

The Medicare data supplied includes care delivered in Colorado facilities in which the Foundation does not perform review, includes unmanageable acute care stays, etc. The A.H.S. Medicaid study (April 1975) attempts to take into account some (but not all) of these considerations and therefore, may give a more accurate indication of PSRO effectiveness although the time periods are too short to state effectiveness in a conclusive manner.

Utilization Rate Methodology

Many drawbacks are inherent in preparing data displays when the project completion date precludes an in-depth study design and verification of figures supplied by outside sources. Yet further, the utilization rate methodology used in this project may be criticized when used on short time periods.

A recent article appearing in Medical Care (January 1976, "Critique of an Earlier Study of the Sacramento Medical Care Foundation's Certified Hospital Admission Program - CHAP) discusses such criticism:

"...When a before-and-after type of program evaluation is attempted based on a comparison of only two short periods of time, two related problems may arise:

1) the chosen baseline period may not be representative or adequate...; and, more importantly,

2) the method of projecting utilization trends from the baseline period may not take covariant factors into account.

"...one may question the validity of making linear projections in a situation where hospital utilization may have been declining for some period of time..."

This type of criticism could be partially valid when directed towards the Medicaid patient day savings (three years of data). It appears that the Medicare data provides a better base (1970-1975) upon which trends can be determined.

In calculating the Medicare cost avoidance estimates, straight linear projections were not used. The rate of change in utilization (trend) was noted and crude smoothing techniques were applied. Thus, the observed seasonal variations were allowed for but, the baseline period may not have been of sufficient duration to determine extended period cyclical variation.

Cost Avoidance Calculations

The Medicare patient days per 1,000 eligibles for 1971 through 1974 shows a decreasing utilization pattern (4006, 3845, 3731, 3376). The rate of utilization decrease for the period 1971-1973 was slowing down (4%, 3%); however, in 1974 the rate of utilization decrease accelerated (9.5%). If the previously noted trend had continued (4% to 3% = 75% of the previous year's rate) then, 1974's rate would have been 2.25% (75% of 3%). Instead, the rate of decrease was 317% (9.5% of 3%). Therefore, the calculation of Medicare days reduced in 1974 is based on the difference between the observed and the previous trend projections:

1974 Projection	2.25% - 100% = 97.75% x 3,731	=	3,647
1974 Observed		=	3,376
Reduction in days per 1,000 eligibles			271

Observations of Interest

The patient days per 1,000 eligibles utilization rate comparison (Ref. 76-03-01) between Colorado and the combined Kansas and Nebraska data show quite similar characteristics in seasonal shifts until the first six months of 1974, a period that coincides with the current level of implementation in Colorado PSRO inpatient review. At that point, both Kansas and Nebraska again follow the pattern established in 1972 and 1973 and swing upward while Colorado, unlike its own pattern from the previous two years continues downward.

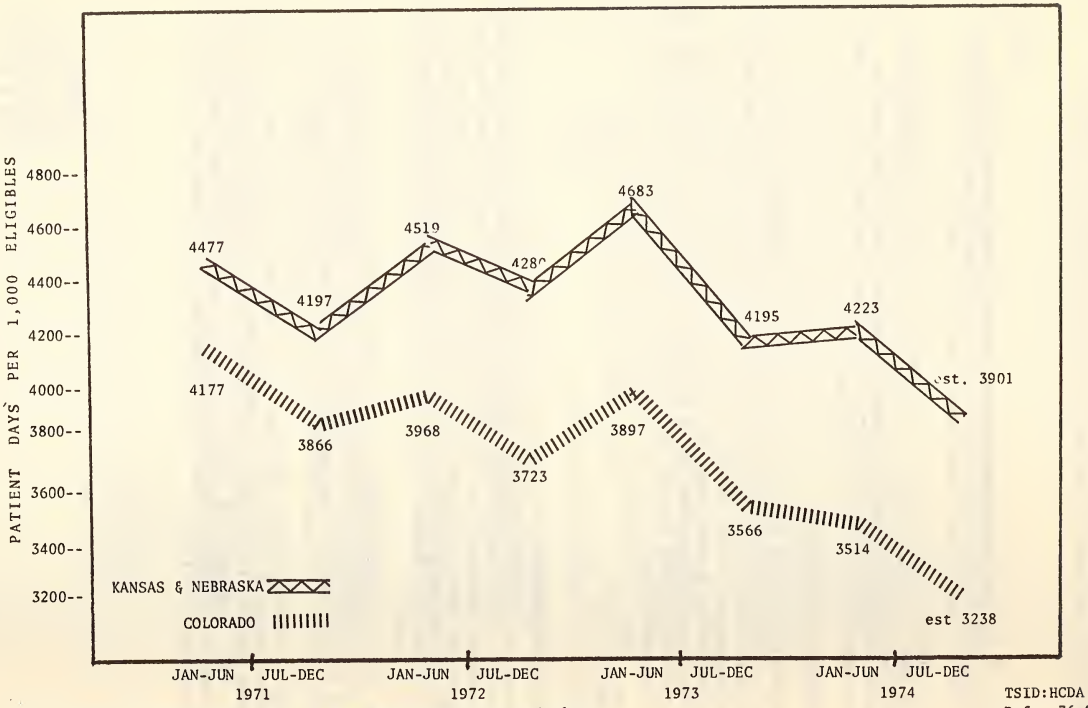
Colorado continues to increase the gap in patient day utilization rates compared to that of Kansas and Nebraska from 92.4% in 1971 to 83.1% in 1974 (Ref. 76-03-02). Comparing Nebraska against Kansas shows a relatively constant ratio (displayed as a horizontal straight line) going from 95.5% in 1971 to only 95.6% in 1974.

Similarly, in a reverse manner, the inpatient charges (Ref. 75-03-03) for each eligible in Colorado compared to Kansas and Nebraska decreased by 10% (120.5% - 1971 to 110.5% - 1974) while comparing Kansas with Nebraska indicates and increase of 4% (96.3% - 1971, 100.3% - 1974). Comparing each group against base year 1971 shows that the 1974 dollar charge per eligible in Colorado increased only 11.1% compared to Kansas and Nebraska aggregate of 21.2%.

UTILIZATION RATES

PATIENT DAYS PER 1,000 ELIGIBLES

MEDICARE



REPORT SOURCE: MADOC data given to Hank Rael (CFMC) via telephone by Fischer and Hargas of HEW office of Research and Statistics

TSID:HCDA
Ref.: 76-03-01
HARRIS
Feb. 17, 1976

COLORADO FOUNDATION FOR MEDICAL CARE

TECHNICAL SUPPORT & INFORMATION DEPARTMENT
Health Care Data Analysis Division

Memorandum Report:

REVISED

ANALYSIS OF DATA PREPARED FOR PRESENTATION TO THE
HOUSE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
February 18, 1976

At the request of R. L. Simmons, M.D., Associate Medical Director of Health Care Data Analysis Division, this revision of the original study (HCDA 76-03, February 18, 1976) has been prepared for the purpose of supplementing the initial study by the inclusion of 1969 and 1970 Medicare data not previously available. An additional function was the verification of the statistics supporting Dr. K.A. Platt's presentation to the House Commerce Health Subcommittee and contained in the Colorado PSRO Activity Profile, February 16, 1976 which accompanied that testimony.

The process of corroborating the figures involved in the Activity Profile and in the text of Dr. Platt's speech included verifying the data contained in the printed reports received from ORS with those included in the first study. Due to time constraints, a portion of the original data had been obtained in a telephone conversation with Charles Fisher, HEW (Health, Education and Welfare) Office of Research and Statistics (ORS). Some differences were noted when a comparison was made of the same data received in "hard copy" form from ORS on March 2, 1976. There were some additional minor computational or typographical errors noted in the profile and in the testimony. All discrepancies have been noted on copies of the reports that are maintained in this study file (76-03A).

Using as a base the printed data received from HEW, the attached graphs have been produced covering average length of stay (LOS) (Ref. HCDA: 76-03A-01), Medicare discharges per 1,000 eligibles (Ref. HCDA: 76-03A-02) and patient days per 1,000 eligibles (Ref. HCDA: 76-03A-03 and 76-03A-04).

Each graph shows a six-year period comparing Colorado to a weighted average aggregate of Kansas-Nebraska. This period of time includes four and one-half years of utilization prior to partial PSRO prototype review (August 1973) and one year of utilization following implementation of statewide PSRO review (January 1974). The two comparison states, Kansas and Nebraska, were chosen because of their tangential locations to Colorado and the absence of operational concurrent review systems for the time period studied upon which to base utilization trends.

In all cases, the second half of 1974 statistics were estimated on the basis of previously noted ratios between first and second halves of each year and trends. The dotted line displayed in 1974 was an extension of Colorado's data

Memorandum Report
(continued)

(Ref. HCDA: 76-03A-03) and it represents the projected trend for that year. This projection was calculated on the basis of previous annual rates of change.

The new data in tabular form have been included with this study for reference. These tables present the statistics on a semiannual basis which is consistent with the raw figures received from ORS - except for the number of eligibles which were provided by ORS on an annual basis. For graphing purposes, annual figures were used throughout the displays to avoid the confusing serrated appearance created by seasonal fluctuations which are normal in hospital utilization.

However, unless an exact linear relationship exists between variables, the point-to-point graphing of annual averages may obscure the overall trend. Display 76-03A-03, patient days per 1,000 eligibles, presents an example of this problem. Display 76-03A-04 represents the same original data as the previous graph, but the curves have been mathematically determined as the "best fitting" to the six-year sum of the data and the trends are more discernible. The technique used in this case was the application of quadratic regression. As can be seen from this refined graph, the Kansas-Nebraska total of patient days per 1,000 eligibles appears to be leveling off in 1974, while Colorado's utilization shows a continuing decrease in slope.

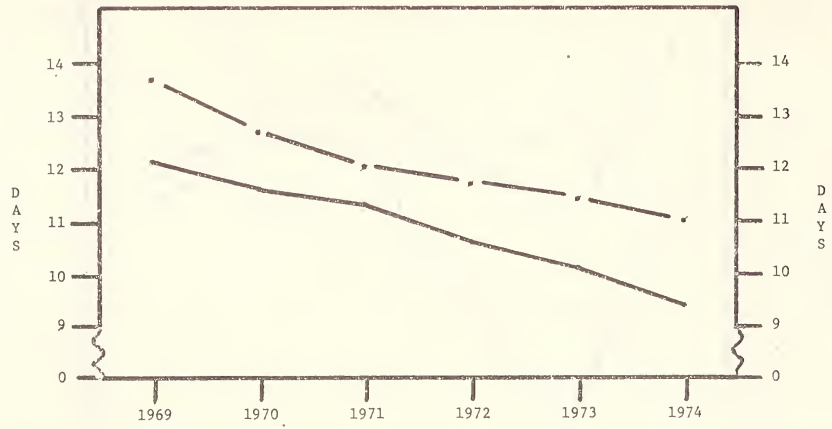
SZ:sr

MEDICARE AVERAGE

LENGTH OF STAY

Key:

	1969	1970	1971	1972	1973	1974
Kansas/Nebraska	13.7	12.7	12.0	11.7	11.4	11.0
Colorado	12.1	11.6	11.3	10.6	10.1	9.4



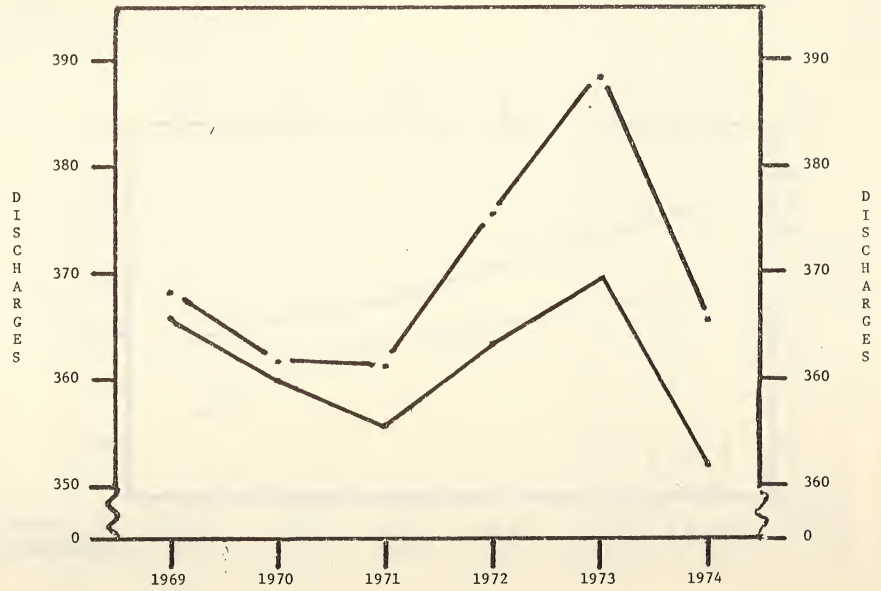
Source: Bureau of Health Insurance
Office of Research and Statistics
Table AA5A - Aged, Hospital Insurance

TSID:HCDA
REF.: 76-03A-01
ZIMMER/dj
April 23, 1976
Page 3 of 6

MEDICARE DISCHARGES

PER 1,000 ELIGIBLES

	1969	1970	1971	1972	1973	1974
Kansas/Nebraska	368.3	361.8	361.4	375.6	388.6	365.9
Colorado	365.8	360.0	355.7	363.2	369.9	352.1



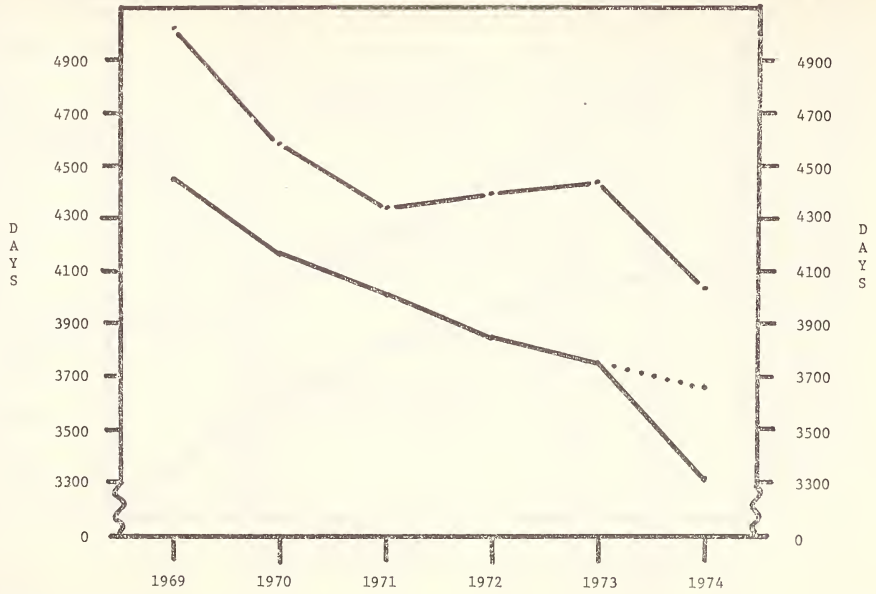
Source: Bureau of Health Insurance
Office of Research and Statistics
Table AA5A - Aged, Hospital Insurance

TSID:HCDA
REF.: 76-03A-02
Zimmer/dj
April 23, 1976
Page 4 of 6

MEDICARE PATIENT DAYS

PER 1,000 ELIGIBLES

Key:						
Kansas/Nebraska	5056.4	4591.7	4337.0	4399.7	4438.1	4021.7
Colorado	4442.5	4189.9	4006.4	3850.4	3746.3	3302.7
Colorado Projected						3667.6



Source: Bureau of Health Insurance
Office of Research and Statistics
Table AA5A - Aged, Hospital Insurance

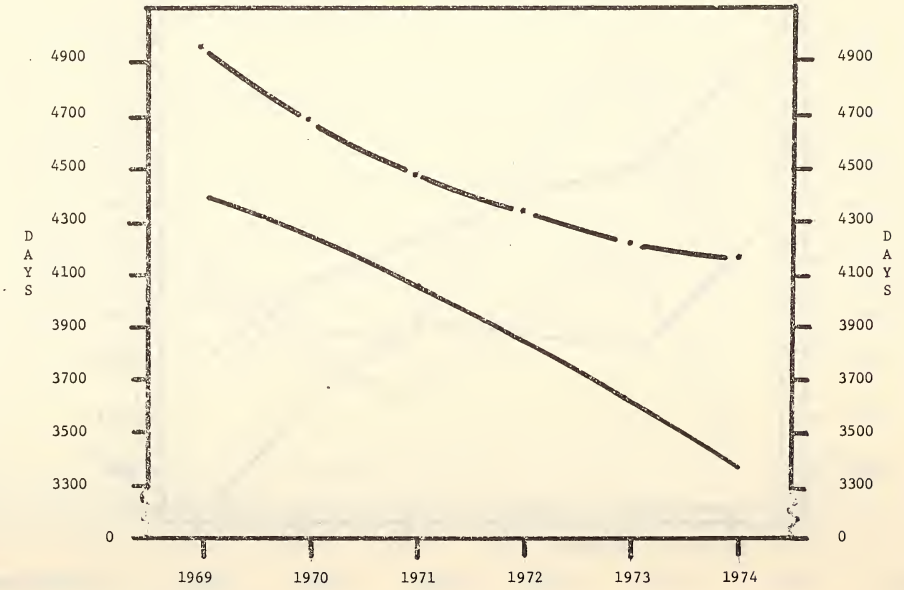
TSID:HCDA
REF.: 76-03A-03
ZIMMER/dj
May 7, 1976

MEDICARE PATIENT DAYS PER 1,000 ELIGIBLES

(QUADRATIC REGRESSION CURVES)

KEY:

	1969	1970	1971	1972	1973	1974
Kansas/Nebraska	4956.1	4696.0	4486.3	4327.0	4218.1	4159.6
Colorado	4436.3	4231.0	4025.7	3820.4	3615.1	3409.8



Source: Bureau of Health Insurance
Office of Research and Statistics
Table AA5A - Aged, Hospital Insurance

TSID:HCDA
Ref.: 76-03A-04
ZIMMER/ms
May 10, 1976
Page 6 of 6

TECHNICAL SUPPORT & INFORMATION DEPARTMENT
Health Care Data Analysis Division

MEMORANDUM:

TO: STUDY FILE - HCDA:76-03A
"Analysis of Data Prepared for Presentation to the House Subcommittee on Health and the Environment - Feb. 18, 1976"

FROM: Jim Harris, Manager, Health Care Data Analysis Division JWH

Date: 29 June 1976

SUBJECT: Telephone Conversation with Charles Fischer
Office of Research & Statistics (ORS), SSA

On 28 June, Charles Fischer called concerning a request for information on Medicare utilization originally requested from Ms. Marty Heppel on 21 June 1976. Related background information concerning that request can be found in a documenting memorandum filed under Study HCDA: 76-03A (29 June 1976:Zimmer).

The following information (Table I) from Fischer is based on a sample of Medicare bills submitted for payment on patients age 65 or older. Geographic location (columns 2-5) is based on patient's State of residence, not the State of service.

TABLE I

Medicare Admission Rates/1,000 Eligibles

Year (1)	Colorado (2)	Kansas (3)	Nebraska (4)	U. S. (5)
1970	378.2	361.3	357.9	299.3
1971	378.7	364.7	371.7	302.8
1972	378.4	377.1	380.1	311.6
1973	386.1	390.0	391.3	317.1
1974	389.7	399.7	403.5	329.0
1975	391.3	401.5	399.9	331.9

Patient days for these same patients are represented in Table II and are rounded to the nearest 1,000 days. The patient days data for 1974 and 1975 were not given because of what Fischer described as "may not be believable" and require further checking.

TABLE II

Medicare Patient Days (000)

Year (1)	Colorado (2)	Kansas (3)	Nebraska (4)
1970	786	1,227	783
1971	762	1,178	770
1972	738	1,172	779
1973	745	1,224	795

Fischer mentioned that they are currently structuring a file that will allow an analysis of utilization on Colorado residence discharged from Colorado facilities. This information should be available in October 1976.

JWH/hd

TECHNICAL SUPPORT & INFORMATION DEPARTMENT
Health Care Data Analysis Division

MEMORANDUM:

TO: STUDY FILE - HCDA:76-03
"Analysis of Data Prepared for Presentation to the House
Subcommittee on Health and the Environment - Feb. 18, 1976

FROM: Suzanne M. Zimmer, Health Care Data Analyst
Health Care Data Analysis Division

SUBJECT: Telephone Conversations Concerning MADOC (Medicare Analysis & Days of Care) Data with the Office of Research & Statistics (ORS), June 24, 1976

Date: June 29, 1976

The first conversation was held with Mr. Dave Gibson of ORS. Participants from the Foundation were myself and Jim Harris, Manager of HCDA. The following points were discussed:

1. Medpar statistics, which are MADOC's replacement, should be available for the last half of 1974 and the first half of 1975 from ORS in the fall of this year - probably October.

2. In response to this Division's question concerning exclusions from the MADOC count of patients discharged, Mr. Gibson explained that patients with stays in excess of 40 days are not counted, nor are patients from short-term care units which are associated with long term care facilities. Exclusions were being investigated because MADOC discharge figures were 5% to 10% lower than CAP statistics for the same period. Other possible explanations mentioned by Mr. Gibson were the data collection cut-off date used by ORS which is six months following the period covered, and the fact that hospitals which are in the process of transferring ownership are not included.

3. Mr. Gibson informed us that a study by their office evaluating the impact of PSRO on utilization is currently under way. The study is focusing on certain "prototype" PSROs - Colorado being one. Ms. Maura Kolins of ORS is conducting the study and it was suggested that she be contacted for further information.

Mr. Charles Fischer of ORS called this Division later in the day to respond to another of our questions - whether any reports were available based upon residence of the beneficiary. He informed us that the MADOC tables we had received and used in Studies 75-03 and 03A were exactly that. This means that the count of individuals in their reports included some who were actually hospitalzed in other states. It was also mentioned that data was available based on admissions rather than discharges which was collected by location (state) of the provider.

Mr. Fischer also mentioned that a processing problem had existed at ORS which might have affected the figures for the last half of 1974 and possibly the first half of 1974. However, he did not explain the nature of the problem or how it might have affected the statistics.

SMZ/hd

Dr. BUSSMAN. In summary, we support the bill and pledge to you that we will work hard to make the PSRO provisions work.

Mr. Chairman, this concludes my testimony. We will be glad to answer any questions you or other members of the committee may have.

Mr. CARTER. Would you elaborate on your testimony concerning the need for Federal payment for the defense costs of suits against the PSRO?

Dr. BUSSMAN. Yes; we, at the present time—all the PSRO's with maybe one or two exceptions—subscribe to an insurance policy made available through our national organization which provides for payment of judgments which, I understand, cannot be legally assumed by the Department of HEW and also provides for defense costs with a deductible which the Department, the Bureau of Quality Assurance, has agreed to pay.

The Bureau of Quality Assurance pays the cost of the premium and will assume the cost of the deductible. They in turn would not be required under this policy to assume the cost of legal defense and cannot, I understand, through Federal legislation, pay the cost of judgments. But we have some real concern that this type of insurance may not be generally available if a series of suits were to be filed by the medicaid mills in response to this present legislation.

We interviewed probably 15 or 20 different insurance companies nationally and finally found a carrier that was willing to write this type of coverage. I would really have some great misgivings if the Federal Government did not assume some of this responsibility and that we could continue to find this in the present private market.

Mr. CARTER. Personally, I have sympathy for you. I agree you should have coverage, but I want to tell you that is very, very controversial. We found that out in the course of our swine flu hearings. And it may be very difficult.

Dr. BUSSMAN. We are not talking about malpractice coverage, you understand.

Mr. CARTER. Of course. You are talking about coverage for PSRO's who check into these fraud cases.

Dr. BUSSMAN. Yes, fraud cases.

Mr. CARTER. The Senate bill provides that PSRO's give data, too. It does not seem to identify any individual to the health planning agencies. Do you agree?

Dr. BUSSMAN. We agree entirely, and most of the PSRO's have already entered into a memorandum of understanding with their local HSA's in those areas in which they have been activated.

Mr. CARTER. How many PSRO's do you think would be ready and willing to undertake this additional review responsibility of ambulatory care?

Dr. BUSSMAN. Well, when the Bureau of Quality Assurance recently advertised for proposals to participate in ambulatory care they received 25 proposals and have funded 6 as demonstration projects. This does not entirely answer your question, I understand.

Perhaps only a small number, a handful, of PSRO's are presently ready to assume this obligation. I understand, though, from direct communication with them that the PSRO in the city of New York are more than anxious to do this, and we understand that is one of the areas in which that problem is most acute.

Mr. CARTER. Are they anxious?

Dr. BUSSMAN. They are anxious and ready.

Mr. CARTER. They are willing to tackle quite a job, I will say that.

How do you anticipate PSRO's could deal with factors, and what do you think of factoring?

Dr. BUSSMAN. I really have so little knowledge of this. I do not really know exactly what we are talking about in factoring. I have read what is in the legislation. I do not know how this compares with the standard practice of turning over accounts receivable to collection agencies. I think there is no objection to that. And I do understand that in some areas physicians are induced to sell their accounts receivable to other organizations who in turn will collect them, and this is declared by the AMA to be unethical.

I just do not know how widespread their abuse is.

Mr. CARTER. This has to do particularly with medicaid bills which are sometimes as long as 5 months overdue. Some physicians sell those bills or give them away on a percentage basis. What do you think of that?

Mr. Fullerton?

Dr. BUSSMAN. I would be opposed to this as our local organization and medical societies have been for a long time, but I really was unaware of the extent of the problem until I heard the testimony this morning.

Mr. FULLERTON. As far as I understand it, Dr. Carter, the selling of bills in this fashion to factoring firms does run into ethical problems, under the AMA ethical policy. I think factoring is not a problem that PSRO's are equipped to deal with.

It arises out of the factors that you described, that is, the bills are so late in being paid and the physician needs the money. He wants to have the income arrive currently with the services he provides. And I could understand why a physician would respond to that kind of a situation in the way that they do. Our general position is that we would agree with the provisions in the Senate-passed bill which would stop that kind of thing. Moreover, we would urge State agencies or whoever can do it to urge the States to do better in getting their bills paid.

Mr. CARTER. Do you know what the average percentage is which these factors charge for their work?

Mr. FULLERTON. I do not know what that would be except by reference to the Aging Committee report.

Mr. CARTER. Thank you for your testimony, gentlemen.

The next witness is Dr. Raymond Holden.

Dr. Holden, we want to welcome you here and we will listen closely to your testimony.

STATEMENT OF RAYMOND T. HOLDEN, M.D., CHAIRMAN, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR, DEPARTMENT OF LEGISLATION, AND DAN HILL, ASSISTANT DIRECTOR, DEPARTMENT OF LEGISLATION

Dr. HOLDEN. Thank you, Mr. Chairman.

Mr. CARTER. Would you please identify the gentlemen who are with you?

Dr. HOLDEN. I am Raymond T. Holden, a physician in practice in Washington, D.C., and I am chairman of the board of trustees of the American Medical Association. With me today is Mr. Harry Peterson, director of our Department of Legislation and the assistant director, Mr. Dan Hill.

I am very pleased to be here, Mr. Chairman, to offer our support for the principles and objectives of H.R. 15536.

We indeed support the concept expressed in H.R. 15536 which is intended to create a means of identifying and regulating certain cases of fraud and abuse that may exist in the medicare, medicaid, and maternal and child health programs. The American Medical Association deplores fraud and abuse in any governmental health program and believes that steps should be taken to assure the integrity of all such programs.

The medical profession wishes to cooperate with programs intended to identify and to weed out those few medical practitioners who may engage in fraud or abuse. In fact, the medical profession, in its respective professional societies, has often gone on record as stating its desire to cooperate with State and Federal authorities in identifying and putting an end to any questionable activities as they relate to the medical profession.

Too often, however, State and Federal authorities have not allowed the organized medical profession meaningful authority, even in a cooperative role providing assistance.

As you are well aware, Mr. Chairman, organized medicine is, through its medical societies, primarily directed toward scientific activities and has no direct licensing or legal enforcement responsibilities or functions. We do, however, recognize our responsibility to the public and most certainly will cooperate in programs intended to weed out those activities performed by physicians which are fraudulent or which constitute abuse.

Earlier this year, in July, our house of delegates adopted the following stand—

> The American Medical Association condemns and deplores all acts of fraud and wrongdoing, including in particular any wrongful acts as recently reported in the medicare and medicaid programs. We urge that responsible government agencies proceed with all due speed in the prosecution under the provisions of due legal process of all who are charged with fraudulent misconduct.
>
> We will continue to offer our cooperation and assistance in bringing to an end such activities.

At the same session the house of delegates approved two model State bills prepared by our association and intended to strengthen the disciplinary procedures and power of State licensing and regulating bodies.

We must point out that many of the individuals who engage in fraud or abuse in the Federal programs may not be members of medical societies. Therefore, the moral persuasion and other influence which a medical society may exert become more limited, and more effective measures are needed. Given the tools, the medical profession can play a meaningful and effective role. This bill extends such a role for professional associations. The most effective measures for control, however, are reposed in the State agencies having licensing and other legally enforceable disciplinary authority.

Recent activities that have come to light in connection with the medicaid mills are offensive to any person, but especially so to the medical profession.

We believe that the bill presently pending before you is one approach to addressing the problem and, as I have indicated earlier, the American Medical Association supports the principles embodied therein. Recognizing, however, that those who may be involved in improper activities are only a small proportion of the total numbers of physicians involved in the health programs, we feel it is important that the corrective measures seek to accomplish their purpose without inflicting punitive measures upon the vast majority who are dedicated in serving their patients.

Notwithstanding our overall support, we would be less than candid with you, if we did not point out certain concerns that we have over the legislation as it is presently written.

ASSIGNMENTS

The bill would also prohibit physicians from assigning—or transferring—claims for payment under medicare or medicaid to another person who would then claim payment under the program. It states, further, that this would not preclude a transfer to another if other than the person was paid compensation on a basis other than on the amount of billings made or payments collected.

Similiar provisions would apply to assignment of claims by part A providers. The assignment prohibition is broad and we must raise a question as to whether its scope may cover unintended circumstances. For instance, would customary assignments by teaching physicians for beneficial training purposes now be prohibited?

DISCLOSURE OF INFORMATION

Other provisions of the bill create more serious problems. They would amend title XI by providing that the Secretary of HEW would by regulation require "any entity" which is "a provider or supplier of items or services" which furnishes services or items reimbursable under titles XVIII, XIX or V, to comply with any request made by the Secretary for certain information.

That information would include business dealings between the entity and any persons having a financial or ownership interest in the entity, and a consolidated certified cost report with respect to costs and charges.

We are concerned over the lack of clarity and the intent of these provisions. As you know, there is no definition of the terms "provider" or "entity" in title XI, nor is there a definition of "supplier of items or services."

A "provider" as used in title XI in reference to information reporting requirements could, we believe, be interpreted as including a physician. The implications of this, if it were so interpreted, would be that all physicians would be subject to this provision, and as a result physicians—singly or practicing in groups—might be required to provide the extensive information. Such physician need not be a person connected with a "shared health facility."

Since this provision refers to activities irrespective of where they occur and since the major thrust of this legislation is to cover medicaid mills, it is inconsistent that reporting requirements should be potentially applicable to any physician who happens to provide services to medicare, medicaid, or title V beneficiaries.

We urge, moreover, that provision be made that only those individuals who have a financial or ownership interest in the entities sought to be controlled should be the ones required to make the reports called for under this legislation.

SHARED HEALTH FACILITIES

We are also concerned about the applicability of the provisions of the act pertaining to "shared health facilities." The definition, in essence, states that such facility is one in which two or more practitioners practice in a common location—or a substantial number of patients are referred to such practitioners by other practitioners at a common location—share common areas, and in which a person other than all of such practitioners is in charge of, controls, manages, or supervises substantial aspects for the arrangement or operation for the delivery of health or medical services at the common location.

The definition does exclude a provider of services and an HMO (as those terms are defined in the medicare law), as well as an arrangement under which practitioners practice as a partnership, professional service corporation or other legal entity, provided that the members of the supporting staff are employees of the entity and provided that, if applicable, any office manager or other similar person, is an employee of the entity and his compensation is customary and not excessive.

To be thus exempted, however, there must be no person described in the earlier provision, i.e., one who is in charge of, controls, manages or supervises substantial aspects of the arrangement or operation.

We believe that this definition should be questioned in two basic aspects. First, the definition does not describe the "medicaid mill" in terms of improper activities, which, in our opinion, is the real issue in in "medicaid mills." It would seem to us that a "medicaid mill", a mode of improper practice and not a structure, is one that provides unnecessary, improper or excessive services or bills for services not provided.

The definition in the proposed legislation, however, seeks to define a "medicaid mill" more in terms of a structure or facility. Consequently, such a definition will cover physicians who under no circumstances should be thought of as providing improper services.

This concern is further exemplified by our second major objection to the definition. This is in the definition's attempt to exclude certain practices. The final clause in the definition—that there is no person described in clause (3)—is objectionable because of its potential effect in removing most exemptions. There could be many situations in which a person other than the practitioners is in fact in charge of, controls, manages or supervises substantial aspects of operation or the delivery of health or medical services. These include the management of business facilities, the management of the contractual relationships, the administrative aspects of the arrangement and other situations.

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We believe that should the definition be retained as it is in the present legislation that the language "and there is no person described in clause (3)" should be deleted.

Further provisions of the bill would increase the penalties for fraud and abuse under medicare and medicaid and would add certain amendments to the PSRO provisions of the Social Security Act.

PSRO AMENDMENTS

As to the PSRO amendments, a PSRO would be granted review authority for specified types of health care services or specified providers or practitioners, thus avoiding the present requirements of the law to review all ambulatory care if authority to review other than inpatient services is requested.

This apparently would allow the PSRO to review "shared health facilities." However, the provisions specifically allowing this special ambulatory care review speak in terms of "specified types of services or specified providers." This goes beyond a shared health facility and would seem to allow the Secretary discretion in selecting certain classes of services in ambulatory care for reviews as well as certain practitioners. In our estimation, such authority would go far beyond the presently expressed intent to get at the "medicaid mills."

In any event, the bill should remove any ambiguity which would require any review of specified services in the absence of a specific request by the PSRO. If this broad authority to review "specified" services is allowed, it would be more appropriate to require that those services be identified with specific entities.

The bill would also amend PSRO to allow the Secretary to authorize the PSRO to make "conclusive" review determinations.

This authority is intended to remove potentially duplicative review under certain presently existing medicare provisions pertaining to certification or utilization review. We strongly support this intent. However, the exclusion provided does not specifically mention review by "program review teams."

We believe that if the PSRO is to exercise the function of exclusive review its review should be exclusive of all other utilization review, certification or program review teams. Moreover, even where the "exclusive" review is given to the PSRO, it is limited "for the purpose of payment." The PSRO review should govern determination of quality and necessity of services for all program purposes.

One other amendment that would be made to the PSRO law states that a PSRO "shall" provide data and information to State and Federal agencies which identify or are investigating suspected cases of fraud or abuse. We believe that the amendment would place upon a PSRO a mandatory requirement of providing information to investigatory agencies.

Such a requirement, as desirable as it may first appear in order to reach an existing problem, would in fact attach to the PSRO the character of being an investigatory unit of State or Federal agencies. This was not the original intent for the PSRO.

If a stigma of being an investigatory unit attaches to the PSRO, we are concerned that this might hinder the development of the program. The PSRO should retain unblemished its responsibility for review of services concerning necessity and quality.

We would urge that language at least not to be phrased so as to be mandatory, but provide that the PSRO "may" provide such information. This would allow the PSRO to maintain its role of professional review rather than punitive investigation.

In any event, proper provision must be made to protect confidentiality of the PSRO records.

In conclusion, Mr. Chairman, I would again like to extend to you and your subcommittee the support of the American Medical Association in activities taken to identify and to control fraud and abuse. We are, as always, prepared to work with you and your subcommittee in developing the proper legislation which would accomplish the primary purpose while avoiding unnecessary Federal regulation and control. This cooperation is bound to result in better legislation.

We urge you to consider our recommendations concerning several of the provisions as ones intended to improve the pending legislation.

Mr. Chairman, we would be pleased to respond to any questions the subcommittee may have.

Mr. Chairman, I ask that my entire statement be included in the record, please.

Mr. Rogers. Without objection, it is so ordered.

[Dr. Holden's prepared statement follows:]

Statement of Raymond T. Holden, M.D., Chairman, Board of Trustees, American Medical Association

Mr. Chairman and Members of the Subcommittee: I am Raymond T. Holden, M.D., a physician in practice in Washington, D.C., and I am the Chairman of the Board of Trustees of the American Medical Association. I am pleased to be here today to offer our support for the principles and objectives of H.R. 15536, the Medicare-Medicaid Anti-Fraud Act. With me is Mr. Harry N. Peterson, the Director of our Department of Legislation.

We indeed support the concept expressed in H.R. 15536 which is intended to create a means of identifying and regulating certain cases of fraud and abuse that may exist in the Medicare, Medicaid and Maternal and Child Health programs. The American Medical Association deplores fraud and abuse in any governmental health program and believes that steps should be taken to assure the integrity of all such programs. The medical profession wishes to cooperate with programs intended to identify and to weed out those few medical practitioners who may engage in fraud or abuse. In fact, the medical profession, in its respective professional societies, has often gone on record as stating its desire to cooperate with state and federal authorities in identifying and putting an end to any questionable activities as they relate to the medical profession. Too often, however, state and federal authorities have not allowed the organized medical profession meaningful authority, even in a cooperative role of providing assistance.

As you are well aware, Mr. Chairman, organized medicine is, through its medical societies, primarily directed toward scientific activities and has no direct licensing, or legal enforcement responsibilities or functions. We do, however, recognize our responsibility to the public and most certainly will cooperate in programs intended to weed out those activities performed by physicians which are fraudulent or which constitute abuse. Earlier this year, in July, our House of Delegates adopted the following stand:

"The American Medical Association condemns and deplores all acts of fraud and wrong-doing, including in particular any wrongful acts as recently reported in the Medicaid and Medicare programs. We urge that responsible government agencies proceed with all due speed in the prosecution under the provisions of due legal process of all who are charged with fraudulent misconduct. We will continue to offer our cooperation and assistance in bringing to an end such activities."

At the same session the House of Delegates approved two model state bills prepared by our Association and intended to strengthen the disciplinary procedures and power of state licensing and regulating bodies.

We must point out that many of the individuals who engage in fraud or abuse in the federal programs may not be members of medical societies. Therefore, the moral persuasion and other influence which a medical society may exert becomes more limited, and more effective measures are needed. Given the tools, the medical profession can play a meaningful and effective role. This bill extends such a role for professional associations. The most effective measures for control, however, are reposed in the state agencies having licensing and other legally enforceable disciplinary authority.

Recent activities that have come to light in connection with the "Medicaid mills" are offensive to any person, but especially so to the medical profession.

We believe that the bill presently pending before you is one approach to addressing the problem and, as I have indicated earlier, the American Medical Association supports the principles embodied therein. Recognizing, however, that those who may be involved in improper activities are only a small proportion of the total numbers of physicians involved in the health programs, we feel it is important that the corrective measures seek to accomplish their purpose without inflicting punitive measures upon the vast majority who are dedicated in serving their patients.

Notwithstanding our overall support, we would be less than candid with you, if we did not point out certain concerns that we have over the legislation as it is presently written.

OFFICE OF CENTRAL FRAUD AND ABUSE CONTROL

The bill would establish an Office of Central Fraud and Abuse Control within HEW to coordinate efforts, to assist state and federal offices, and to initiate investigation in cases of suspected fraud and abuse in certain federal health programs (Maternal and Child Health, Medicare, Medicaid and renal disease programs under the Social Security Act). We believe that the current fraud and abuse activities of HEW are to be commended. And while the greatly increased efforts were undertaken without the need for new statutory authority, the bill provisions may well serve to create additional emphasis for this effort.

ASSIGNMENTS

The bill would also prohibit physicians from assigning (or transferring) claims for payment under Medicare or Medicaid to another person who would then claim payment under the programs. It states, further, that this would not preclude a transfer to another if the other person was paid compensation on a basis other than on the amount of billings made or payments collected. Similar provisions would apply to assignment of claims by Part A providers. The assignment prohibition is broad, and we must raise a question as to whether its scope may cover unintended circumstances. For instance, would customary assignments by teaching physicians for beneficial training purposes now be prohibited?

DISCLOSURE OF INFORMATION

Other provisions of the bill create more serious problems. They would amend Title XI by providing that the Secretary of HEW would by regulation require "any entity" which is "a provider or supplier of items or services (including any 'shared health facility', as defined in section 1132, or any practitioner or supplier affiliated with such facility)" which furnishes services or items reimburesable under Titles XVIII, XIX, or V, to comply with any request made by the Secretary for certain information. That information would include business dealings between the entity and any persons having a financial or ownership interest in the entity, and a consolidated certified cost report with respect to costs and charges. An entity would be exempted from information reporting if it does not furnish a significant volume of items or services paid for under Titles XVIII, XIX or V. The term "significant volume" would be "as defined by regulations of the Secretary".

We are concerned over the lack of clarity and the intent of these provisions. As you know, there is no definition of the terms "provider" or "entity" in Title XI, nor is there a definition of "supplier of items or services." When a later provision in the bill amending Title XI (referring to a "shared health facility") uses the term "provider of services," it specifically qualifies it by referring to the definition in the Medicare Act (i.e., a facility such as a hospital or a skilled nursing facility). A "provider" as used in Title XI in reference to information reporting requirements could, we believe, be interpreted as including a physician.

The implications of this, if it were so interpreted, would be that all physicians would be subject to this provision, and as a result physicians—singly or practicing in groups—might be required to provide the extensive information. Such physician need not be a person connected with a "shared health facility". Since this provision refers to activities irrespective of where they occur and since the major thrust of this legislation is to cover "Medicaid mills", it is inconsistent that reporting requirements should be potentially applicable to any physician who happens to provide services to Medicare, Medicaid or Title V beneficiaries.

We urge, moreover, that provision be made that only those individuals who have a financial or ownership interest in the entities sought to be controlled should be the ones required to make the reports called for under this legislation.

SHARED HEALTH FACILITIES

We are also concerned about the applicability of the provisions of the Act pertaining to "shared health facilities". The definition, in essence, states that such a facility is one in which two or more practitioners (who receive payments under Titles V, XVII and XIX which are substantial in amount as determined by the Secretary), practice in a common location (or a substantial number of patients are referred to such practitioners by other practitioners at a common location), share common areas, and in which a person other than all of such practitioners is in charge of, controls, manages, or supervises substantial aspects for the arrangement or operation for the delivery of health or medical services at the common location (or such a person makes available to the practitioners services of supporting staff who are not employees of the practitioners). The definition does exclude a provider of services and an HMO (as those terms are defined in the Medicare law), as well as an arrangement under which practitioners practice as a partnership, professional service corporation or other legal entity, provided that the members of the supporting staff are employees of the entity and provided that, if applicable, any office manager, or other similar person, is an employee of the entity and his compensation is customary and not excessive. To be thus exempted, however, there must be no person described in the earlier provision, i.e., one who is in charge of, controls, manages or supervises substantial aspects of the arrangement or operation.

We believe that this definition should be questioned in two basic aspects. First, the definition does not describe the "Medicaid mill" in terms of improper activities, which, in our opinion, is the real issue in "Medicaid mills". It would seem to us that a "Medicaid mill", a mode of improper practice and not a structure, is one that provides unnecessary, improper or excessive services or bills for services not provided. The definition in the proposed legislation, howver, seeks to define a "Medicaid mill" more in terms of a structure or facility. Consequently, such a definition will cover physicians who under no circumstances should be thought of as providing improper services. And the definition will allow those "Medicaid mills" which do not exactly fit the definition to be outside the purview of the legislation. We believe that the definition could, therefore, be inadequate at both extremes in that it covers some who should not be covered and excludes others who should be covered.

This concern is further exemplified by our second major objection to the definition. This is in the definition's attempt to exclude certain practices. The final clause in the definition (that there is no person described in clause (3)) is objectionable because of its potential effect in removing most exemptions. There could be many situations in which a person other than the practitioners is in fact in charge of, controls, manages, or supervises substantial aspects of operation or the delivery of health or medical services. These include the management of business facilities, the management of the contractual relationships, the administrative aspects of the arrangement and other situations. We believe that should the definition be retained as it is in the present legislation that the language "and there is no person described in clause (3)" should be deleted.

Further provisions of the bill would increase the penalties for fraud and abuse under Medicare or Medicaid and would add certain amendments to the PSRO provisions of the Social Security Act.

PSRO AMENDMENTS

As to the PSRO amendments, a PSRO would be granted review authority for specified types of health care services or specified providers or practitioners, thus avoiding the present requirements of the law to review all ambulatory care if

authority to review other than inpatient services is requested. This apparently would allow the PSRO to review "shared health facilities". In fact the legislation specifies, when the PSRO requests authority to review "shared health facilities", that priority to approving such requests would be given by the Secretary. However, the provisions specifically allowing this special ambulatory care review speak in terms of "specified types of services or specified providers". This goes beyond a shared health facility and would seem to allow the Secretary discretion in selecting certain classes of services and ambulatory care for review as well as certain practitioners. If for example, the Secretary allowed certain ambulatory care services to be reviewed, those ambulatory care services provided in any ambulatory setting would then be reviewed. In our estimation such authority would go far beyond the presently expressed intent to get at the "Medicaid mills". In any event, the bill should remove any ambiguity which would require any review of specified services in the absence of a specific request by the PSRO. If this broad authority to review "specified" services is allowed, it would be more appropriate to require that those services be identified with specific entities.

The bill would also amend PSRO to allow the Secretary to authorize the PSRO to make "conclusive" review determinations (for those services reviewed by it which are specified services). This authority is intended to remove potentially duplicative review under certain presently existing Medicare provisions pertaining to certification or utilization review. We strongly support this intent. However, the exclusion provided does not specifically mention review by "program review teams". We believe that if the PSRO is to exercise the function of exclusive review its review should be exclusive of all other utilization review, certification or "program review teams." Moreover, even where the "exclusive" review is given to the PSRO, it is limited "for the purpose of payment". The PSRO review should govern determination of quality and necessity of services for all program purposes.

One other amendment that would be made to the PSRO law states that a PSRO "shall" provide data and information to state and federal agencies which identify or are investigating suspected cases of fraud or abuse. We believe that the amendment would place upon a PSRO a mandatory requirement of providing information to investigatory agencies. Such a requirement, as desirable as it may first appear in order to reach an existing problem, would in fact attach to the PSRO the character of being an investigatory unit of state or federal agencies. This was not the original intent for the PSRO. If a stigma of being an investigatory unit attaches to the PSRO, we are concerned that this might hinder the development of the program. The PSRO should retain unblemished its responsibility for review of services concerning necessity and quality. We would urge that language at least not to be phrased so as to be mandatory, but provide that the PSRO "may" provide such information. This would allow the PSRO to maintain its role of professional review rather than punitive investigation. In any event, proper provision must be made to protect confidentiality of the PSRO records.

CONCLUSION

Mr. Chairman, we believe that fraud and abuse must be identified and, where appropriate, prosecuted. We do have concerns, nevertheless, that H.R. 15536, as presently written, might have adverse effects upon beneficiaries of federal health programs. It might then have a much greater adverse social impact than would the problem toward which this bill is directed. The primary need is to identify those cases where fraud and abuse may exist.

The vast majority of physicians are without question honest, dedicated, and cooperative. Those few who engage in fraud or abuse are the ones who should be identified and disciplined. However, if legislation is now passed which in effect could question the activities and decisions of every physician for the sake of reaching a few, those federal health programs could further disillusion physicians and beneficiaries.

We believe that the legislation presently pending before you does embody a good concept, but we also believe that recognition must be given of the adverse impact which could occur if the legislation were passed as presently proposed. Its scope should be fashioned to accomplish its purpose with minimum adverse impact.

In conclusion, Mr. Chairman, I would again like to extend to you and your Subcommittee the support of the American Medical Association in activities taken to identify and to control fraud and abuse. We are, as always, prepared to work with you and your Subcommittee in developing the proper legislation which

would accomplish the primary purpose while avoiding unnecessary federal regulation and control. This cooperation is bound to result in better legislation.

We urge you to consider our recommendations concerning several of the provisions as ones intended to improve the pending legislation.

Mr. Chairman, we would be pleased to respond to any questions the Subcommittee may have.

Dr. HOLDEN. And we would be pleased to respond to any questions that you may have.

Mr. ROGERS. Thank you very much.

Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

I am always glad to hear your testimony, Dr. Holden. It was very, very good. I understand you feel the bill's prohibition against assignment of transferring claims for payment is too broad. Would you please elaborate on that point?

Dr. HOLDEN. If I may, Mr. Chairman, I would like to ask Mr. Peterson to respond to that in order to get it done a little more quickly.

Mr. PETERSON. I would say generally the term "assignment" is a very broad, generic term for a procedure whereby a claim may be transferred to another person, and this may be done for many purposes, many of which have validity and propriety. We raise here, for instance, an example which is very common, as I understand it, with respect to teaching physicians. These physicians may assign their claims for purposes of furthering the teaching programs in the institutions. We would raise the question as to whether, for instance, this beneficial practice might fall within the general prohibition contemplated under the bill.

So we would urge a very careful evaluation of this term.

Mr. ROGERS. Wasn't that provision in the Senate bill?

Mr. PETERSON. There was a provision on assignments in that bill and the bill is introduced in the House.

Mr. ROGERS. We have taken care of that situation.

Dr. HOLDEN. I think our real interest concerned the legitimate assignments as opposed to the questionable transfers. You referred to those latter transfers, Dr. Carter, when you asked about factors. That sort of assignment we do not agree with. But we do feel there are situations in which transfers would be reasonable. Therefore, we would not want overly broad prohibitions.

Mr. CARTER. You mentioned that concern with respect to teaching hospitals, Mr. Peterson. Is that what you said?

Dr. HOLDEN. In teaching hospitals. It is customary in teaching hospitals for the faculty to assign any payments they might receive from medicare or medicaid patients or a percentage of those payments, to a fund which is to improve and extend the teaching program.

This is not uncommon, nor unusual, and it is open and above board and, we think, that sort of assignment is a reasonable one because it does not build in cost into the system.

Mr. CARTER. Thank you, Doctor.

Mr. ROGERS. Dr. Holden, thank you for your testimony. Now, I think it would be helpful to the committee if you would give us proposed language which you think would accomplish your suggestions.

Dr. HOLDEN. We would be delighted to.

Mr. PETERSON. We would be happy to assist your committee and staff in any way we can. While we recognize the intended benefits to be

derived from this bill and we support those intentions and objectives, our concerns are that perhaps the actual application or coverage of the bill may be too broad. Application of the bill as proposed might have some adverse effects and not receive the acceptance we would hope the bill would otherwise receive.

Mr. CARTER. In the end, we do not want to affect those honest practitioners adversely.

Dr. HOLDEN. I can see how the broad definition of "shared health facilities" in the bill could affect my small office, which I share with two colleagues, all of us practicing independently and sharing expenses. I do not believe that is your intent.

Mr. ROGERS. I think there are new definitions in the bill that I wish you could go over and give us your reaction because we are going to try to develop legislation later this afternoon.

Mr. PETERSON. We have seen some of that new draft language, and we still have some difficulty with it, but we would be glad to work further with it.

Mr. ROGERS. If you could let us have your suggestions this afternoon, we would greatly appreciate it.

There is a quorum call. The committee will stand in recess for 10 minutes.

[Brief recess.]

Mr. ROGERS. The committee will come to order, please.

The next witness will be Mr. Mitchell Diamond, treasurer of IMFC Professional Service Corp. Mr. Diamond is accompanied by Ivan Dochter, general counsel.

We welcome you gentlemen to the committee, and we will be pleased to accept your testimony. Your statement will be made a part of the record, in full, at this point, and you may proceed. If you could highlight the points in your statement, it would be helpful to the committee.

STATEMENT OF MITCHELL DIAMOND, TREASURER, IMFC PROFESSIONAL SERVICES CORP., ACCOMPANIED BY IVAN DOCHTER, GENERAL COUNSEL

Mr. DIAMOND. Mr. Chairman and members of the subcommittee: My name is Mitchell Diamond. I am treasurer of IMFC Professional Services, Inc., New York, N.Y. Our company is a member of the Professional Factoring Service Association.

I appreciate the opportunity afforded by the subcommittee to discuss H.R. 12961 as amended by S. 3801, particularly as it relates to the prohibition against assignment by physicians, dentists, pharmacists, surgical suppliers, laboratories, and ambulance companies of claims for services.

As you are aware, the Senate on Monday of this week passed H.R. 12961, with an amendment, which prohibits what has generally been referred to as "factoring" of claims submitted by "providers" to agencies administering medicaid and medicare claims.

The genesis for this action has its origin in hearings before the Subcommittee on Health of the Senate Finance Committee in July of this year. This, plus the revelations engendered by Senator Moss's trip to New York earlier this month has resulted in what is, in fact, the precipitous elimination of an integral part of the health care

delivery system for the poor and indigent in the large metropolitan areas of this country.

"Factoring" does now and has always played an important role in the free enterprise system. Factoring is an institution of honorable tradition and long experience.

It is not my intention in the time allotted to address myself to the advantages of factoring as a financial device but only to say that the U.C.C. as adopted by all the States provides for accounts receivable financing and that based upon a ruling in 1963 by the Comptroller of the Currency factoring was held to be a legitimate bank activity.

I have asked myself why the factoring business that I have engaged in for the past 8 years became illegal? What have I or others engaged in factoring done that cries out for the complete elimination of a proper business activity? What has caused the Senate of the United States on September 20, 1976, to pass a bill which will cause the complete cessation of my business activities?

We must first ask ourselves why must a provider participating in the medicare and medicaid program seek the services of a factoring company? The answer is simple. It is the urgent need for an increased cash flow. The provider's problem for immediate cash to operate and meet the expenses of this business or profession was created by the inability of Government to process his bills for services rendered in a reasonable period of time and, second, that by using a factor he, the provider, is hiring and obtaining that expertise that is required to deal with the complex and cumbersome billing procedures.

It is the provider who makes the ultimate determination of whether or not to factor. It is he, the provider, who must make the determination of the cost of factoring versus the cost of not doing so. He, the provider, need not have a degree in economics to know that if there is no savings, no benefits, he will not factor.

Does the substantial benefit that results from the service we render call for a continuation of our activities? I submit unequivocally that it does.

It appears that the reasoning for the proposed legislation to ban factors and banks from securing an assignment of claims is based upon two primary considerations:

1. That factoring presents an opportunity for greater fraud and abuse by way of incorrect billings and inflated claims.

2. That factoring creates an additional cost to the provider which is indirectly passed on to the program.

I must respectively submit that this reasoning is unsound for the following reasons:

1. Factoring does not, I repeat, does not, present an opportunity for greater fraud and abuse. Does anyone believe that overbilling—the inflated claims—will be eliminated by prohibiting the assignment of the claim? The mere possibility that some factoring company may be engaged in some illegal activity should not cause the enactment of legislation to bar all factors from doing business any more than the illegal activities of a single bank, auto dealer, finance company, savings and loan association, insurance company, or any other business should be permitted to bar all others from continuing such a business.

We submit that there is no rational basis for such a prohibition. What is needed is a sound auditing program that will detect fraud

and abuse by whomever committed The auditing process detecting dishonest billing and punishing the wrongdoer is no different whether it is the assignee or the provider who is doing the billing.

The prevention of fraud in medicaid and medicare billings is no different from any other type of crime prevention. The dishonest party must be made aware that there is a good chance of being caught and that the penalty for the commission of the crime will be severe enough to act as a deterrent.

We commend you for having taken that first step in the establishment of the central fraud and abuse control unit within the Department of HEW, and in increasing the criminal penalty for the commission of such wrongdoing.

The auditing procedure for the detection of fraud would be no different for a provider of services who assigns his accounts receivable than for one that does not assign his receivables.

Experience has shown that it is the provider, not the assignee, who has the greater opportunity to initiate the fraud.

In actuality, it is the factoring company that seeks to detect and insure that the billings are correct in order to protect his investment, since the provider is paid for his services by the factor before auditing is done by the appropriate Government agencies. It is the factoring company who is always available to aid and assist Government in its auditing procedures. It should be noted here that the factor by keeping detailed records of all invoices submitted to the local social service district is fully aware of overpayments that have been made, and when such overpayments or duplicate payments have been made, it has been the factoring company that has promptly refunded the overpayment, (verification of this fact can readily be obtained from the New York City Department of Social Services).

To preclude any possibility that the provider's bills are being inflated or otherwise altered by the provider's assignee it is certainly not necessary to have a "total ban on assignments."

All that is required is that the provider receive the original statement of payments by the agency and that any detected differences between the original invoice submitted and the one paid be reported to the appropriate authorities. In addition, standardized auditing procedures should call for the review in the provider's office of the copy of the invoice he submitted against his medical chart and against the bill as received by the Department of Social Services.

2. Factoring does not create an additional cost to the program and in actuality program costs are decreased when an assignment is used.

It is the provider who makes the determination if factoring is financially advantageous to him after evaluating the costs of factoring against the costs of not doing so.

The provider by electing to use a factoring company is furnished expertise in the area of billing and collection and will be able to avoid the cost of detailed financial recordkeeping permitting him to be free to render his professional services. The alternative of not factoring would be to attempt to borrow from a bank, the use of a billing service and the hiring of additional help for the purpose of recordkeeping.

It logically follows that for a provider to use the services of a factor, it must be financially advantageous to him and if it is advantageous to him, it would be advantageous to the program.

In actuality, the use of the assignment permits the factoring company to charge the provider a lower fee. It is that security device, the assignment, that enables the factoring company to charge a lower fee because there is a lower risk of nonpayment.

The proposed legislation does not prohibit a provider from borrowing but only prohibits the use of an assignment.

The consequence of that alternative method of financing will result in either lower loan proceeds or higher interest rates to this provider because it does not provide the near perfect security that an assignment offers.

Furthermore, all of the abuses that are alleged will continue to exist even if assignments are prohibited. That is, if submission of claims by an agent lending against receivables continues to be carried out without the use of an assignment as a security device. The difference being that the lenders, because they are taking a greater risk, will demand a greater return and following this sample logic will increase the costs to the program.

Of course if medicaid payments were made promptly, there would be no receivables. Hence, no need to discount the provider's paper by the factor. But this is not the case given the redtape and bureaucratic delay present in State and municipal government.

It is the delay in payment that is the root cause which results in increased costs to the system and not the presence of the factor. The factor merely aleviates the problem of delay in payment by discounting the paper. Therefore why legislate a prohibition on an effect, for example, the factor? If you must legislate on this question, legislate the cause, for example, the delay in payments.

What, in effect, I have been trying to say is that we provide a most necessary service to the program. If our service fits the provider's needs, he uses our services; if it doesn't fit his needs, he does not. If the legislation is enacted in its present form so as to bar factors from participation in this field, the result would be that the number of doctors participating in the program would be drastically reduced, making the programs not viable.

I ask the committe now, What alternatives have been devised for the medical community to get funding after the use of secured lending from banks and factors has been cut off?

What is the ambulance company, surgical supply company, pharmacist, dentist, laboratory, and medical doctor to do for funds needed for working capital?

What will happen if these providers shut their doors? Where are the patients to go?

The proprietary ambulance company that has 24-hour service has long replaced the daylight volunteer service company, that would not go into the hazardous areas and that is no longer in existence. The surgical supplier, the pharmacist, and the dentist all have to pay their suppliers currently—often within 10 days. Can they wait 4 to 6 months for the bills to be paid? What do they do for working capital?

The private practitioner is no longer working in the ghetto. He is now part of a group practice for safety, economy, and increased professional proficiency. How does the group now find the urgently needed cash flow?

Mr. Rogers. There is a call to the floor for a vote. The committee will stand in recess for 10 minutes.

[Brief recess.]

Mr. Carter [presiding]. We will proceed.

Mr. Diamond. Thank you, Mr. Chairman. My remarks should be only a moment or so more.

I would like to explain a very basic difference between a medical service provider and an ordinary small businessman.

The businessman can hold off new business until he has received the payments from his last transaction.

Can you imagine a medical service provider telling a patient to come back when the provider can afford to treat him.

Where is the indigent patient to turn? To the local hospital? Waiting lines of up to 7 hours are common—and isn't the cost to the program greater at the hospital?

As responsible businessmen, we petition Government and State. Is there not a more reasonable alternative than prohibition? Yes. The alternative to prohibition is sound, responsible legislative regulation.

We in our industry stand ready to meet with the appropriate governmental agencies, to wit: HEW, the Comptroller General, or any other agency entrusted with the promulgation of sound and reasonable regulations.

If you can identify areas of possible fraud and abuse, we stand ready to help structure regulations to curb such abuses with licensing, standardizations, nad financial responsibility.

What concerns us most, however, is the unorthodox method by which this bill has reached its present status where it is about to be enacted into law conceived in the night and coming out of the closet in the morning with no opportunity for us to present our views except before this forum.

If you want reform to eliminate the abuses present in the system, and in our case the possible problems of secured lenders and factors, this legislation will not serve that purpose.

We suggest that you do not attack the problem in this hastily drawn manner that will cause chaos, interruption, and increased costs to the program, but rather in a manner that will provide an opportunity for the correction of the program's real problems.

Mr. Chairman, there is one other point I would like to make, and it is contained in the addendum to the prepared remarks.

The bill as enacted by the Senate I believe has a technical defect. That being the effective date of the act.

In the event the arguments presented here today are rejected, I request that you add to the end of the bill the following language:

Except as herein otherwise provided nothing in this section shall be deemed to affect or impair rights or obligations heretofore accrued.

This technical addition to the act will enable the factoring company to use the assignment as a security device up and until the effective date of the legislation and enable him to be paid even though the payment may be made by the appropriate governmental agency after the effective date.

Thank you.

Mr. Carter. Do you think that last clause would be necessary?

Mr. Diamond. Yes, I do.

Mr. CARTER. If something was done with the obligation which we already have to you, wouldn't that be an ex post facto law and unconstitutional?

Mr. DIAMOND. Yes, sir.

Mr. CARTER. I wonder if that is really necessary.

Mr. DIAMOND. I would like to have my attorney answer that.

Mr. DOCHTER. We have differed previously with the HEW regulations. It is added for the purpose of clarity to protect that the Government or State agency which would have to have its program amended would comply with what the intent was of Congress.

In other words, if you, in your wisdom, do enact such legislation we rightfully request that we be protected up until the effective date of the legislation.

Mr. CARTER. I believe you are protected already according to the Constitution. We could not obliterate your rights.

Now, you are licensed and bonded by the State of New York, are you not?

Mr. DIAMOND. No, sir, there are no licensing requirements.

Mr. CARTER. Are you bonded?

Mr. DIAMOND. No, sir.

Mr. CARTER. Do you take over all the billing and collecting of doctors' services, or just selected ones?

Mr. DIAMOND. Our function is not to do billing and collecting.

Mr. CARTER. Do you discount?

Mr. DIAMOND. We do discount the bill. I should give you an idea of what we do. We pick up invoices at the doctors' offices—mail being very bad in ghetto areas. We bring them to our office, edit the invoices for clerical correction and for procedural corrections.

We make copies of the invoices by microfilm. We prepare a listing of all of the invoices for the doctor. One week later we send the listing back to the doctor showing him what we purchased, all of the invoice numbers and the amounts, and we give him a check with it.

Mr. CARTER. You take just what you want, then, out of that? You are selective?

Mr. DIAMOND. We review the invoices and only buy those which we think are going to get paid.

Mr. CARTER. What type are they, as a usual thing?

Mr. DIAMOND. Dollar amounts?

Mr. CARTER. No. What types of debts are they?

Mr. DIAMOND. Claims for service. Medicaid.

Mr. CARTER. What about medicare?

Mr. DIAMOND. We do some medicare as well, but mainly medicaid. These claims are from ambulance services and pharmacists and dentists and physicians.

Mr. CARTER. What percentage do you charge for this service?

Mr. DIAMOND. Our charges run from 7 to 12 percent.

Mr. CARTER. Seven to 12 percent per annum?

Mr. DIAMOND. No, sir, that is a discount from the invoice. Let me explain that. The charges cover accounting services, computer services, invoice editing, messenger services, microfilms, resubmission of invoices and a host of other services we perform.

We have a staff of over 20 highly trained people. The turnover of payments is approximately two and a half times per year and slowing down. This yields approximately 22 percent to 30 percent gross profit.

Mr. CARTER. What is the gross profit?

Mr. DIAMOND. Between 22 percent and 30 percent.

Mr. CARTER. Do you discount those bills that much?

Mr. DIAMOND. No, sir. It is the gross profit figure on a yearly basis.

Mr. CARTER. Figured how?

Mr. DIAMOND. On a yearly basis.

Mr. CARTER. That comes from your accumulation, of your 7 or 10 percent.

Mr. DIAMOND. Turnover two and a half times a year, correct. The large cost of the operation must be deducted from that. I am speaking of administration, interest on bank and stockholder loans, cost of equipment, et cetera. In addition, payment disallowances of 5 to 10 percent increase the time of collection and increase our costs.

Furthermore, 12 to 15 percent of the invoices are underpaid after 6 months and up to 1 year. These increase the cost of our operation. One other point never mentioned in any report or hearing, if a doctor is found guilty of fraud and his payments were withheld, it is the factor that often bears the cost of the loss because the provider will often close his business and leave.

In our particular case—I am referring to my company—our net profit before taxes on the total development of the parent and subsidiary companies was less than 10 percent last year. We are ready to submit all those figures.

Mr. CARTER. You say that often they are not paid for a year?

Mr. DIAMOND. That is correct. Or more.

Mr. CARTER. That is rather unusual. We had testimony today that it is a rare thing for medicaid not to be paid within 5 months.

Is that not correct, Mr. Chairman?

Mr. DIAMOND. I am ready to document that going back 8 years.

Mr. CARTER. Again, you discount either 7 to 10 percent. What do you mean 7 or 10 percent, which?

Mr. DIAMOND. It depends on the provider we are dealing with and it depends on the turnover that we got from the individual provider.

Mr. CARTER. And what does that depend on?

Mr. DIAMOND. Let me explain. A physician often gets paid in 3 to 4 months. A dentist will get paid in 4 or 5 months. A laboratory will get paid in 7 or 8 months, average. So we have to figure the cost in each individual case.

Mr. CARTER. Do you figure as installment loan people do on percent per month, or is this just a discount on amount which is owed to the provider?

Mr. DIAMOND. The second point.

Mr. CARTER. It does not vary from 7 to 10 percent.

Mr. DIAMOND. Not from each invoice, no. That is a rate set for the provider and the invoice is discounted.

Mr. CARTER. That is a rate set for your takeout?

Mr. DIAMOND. That is correct.

Mr. CARTER. I cannot see how that procedure does not cost the patient. Perhaps the maximum amount would not be increased but if a physician or a pharmacist or a dentist collected that, certainly your part would be eliminated. Also, what is a "procedural correction" which you mentioned just a few minutes ago? You said in your office

you got these bills, microfilmed them, and edited them for "procedural corrections."

Mr. DIAMOND. We do not ever touch a bill in our office.

Mr. CARTER. Please read your own statement, then. What do you mean?

Mr. DIAMOND. We review these invoicse that the doctors present to us. We look at it for clerical errors. Often they forget to sign a bill, forget to total it, forget to put a complete line of service on it. Those invoices are pulled from his batch and are sent back to the doctor's office for correction.

They do the correction. We do not.

Mr. CARTER. They do the correction?

Mr. DIAMOND. Absolutely.

Mr. CARTER. What you do then is to send this into the medicaid office, for the State of New York in your case, is that corerct?

Mr. DIAMOND. That is correct. We deliver the invoices to medicaid. And the checks, when they are paid are made payable to the provider in his name.

Mr. CARTER. How do you get your money?

Mr. DIAMOND. The system in New York City—we have a designation system. There is a letter filed by the doctor that all the checks that belong in his name are to be given to us and the city holds those checks and gives them to us.

Mr. CARTER. You have to get the doctors' signatures then before you can do anything with them, is that correct?

Mr. DIAMOND. We have a contract that permits us to sign the checks in his name. After we have gotten the checks and have taken the checks from the statement, deposited them, we then return the original vendor statement directly to the doctor.

Mr. CARTER. What is the nature of your physicians' practices by and large? Do you deal with specialists?

Mr. DIAMOND. I believe I deal with an entire range of physicians and companies. Some are young, just out of school with no capital. Some are older, have given up their practice, would like to practice 1 or 2 days a week.

Mr. CARTER. So, you have a contract with each physician you serve. You are not bonded or licensed but when you get that check back from the State you can sign it. You can do anything with it if you wanted to?

Mr. DIAMOND. Yes, sir.

Mr. CARTER. You would not have to turn it over, except you have a moral obligation to do that. You are not bonded or licensed. It is not guaranteed. I can see how you would provide a service, but certainly I think that you should be bonded and licensed.

Mr. DIAMOND. We do not object to that, sir, and we ask for regulation for the entire industry and standardization so that the methods that we use that are good——

Mr. CARTER. What percentage of your clients are FMG's?

Mr. DIAMOND. Foreign medical graduate. It varies from year to year. Doctors come and go.

Mr. CARTER. What percent would it be approximately a year?

Mr. DIAMOND. Maybe as many as 25 percent at times and at other times as low as 10, 5.

Mr. CARTER. As low as 5 and sometimes 25. Is it ever 50?

Mr. DIAMOND. Truthfully, I have never gone through any list to determine that.

Mr. CARTER. What is the age of these physicians for whom you do this work?

Mr. DIAMOND. I have physicians that are young and some that are in their late sixties, still practicing and do not want a private practice but would prefer practicing someplace 1 or 2 days a week.

Mr. CARTER. Actually, those claims are not so difficult to handle. All physicians have to do, if they have a good clerk who could list the bills, is send them in to the State. That is all there is to it. I have an office myself and I know.

Mr. DIAMOND. Sir——

Mr. CARTER. I am not in practice now, but my nephew is, and he does this.

Thank you, Mr. Chairman.

Mr. DOCHTER. May I respond, Dr. Carter? I would like to clear something up. We sat here this morning and we heard HEW officials seem to deny with tongue in cheeck the responsibilities that Congress has entrusted them to administer a program, and they put the blame on the State.

You had the former State administrator here from New York, of the program, Beverlee Myers, who resigned in some degree of protest because of the failure of the system to accomplish its aims. The experience that your nephew has, sir, in his home State is different than any provider has in New York.

We are so bogged down with redtape, administrative regulations. We have rules that were written on Monday that were effective 3 weeks ago. We have the failure of local and State authorities to communicate with providers that it is not a simple thing to submit a bill now by a doctor.

They change what a first visit is, what a second visit is, when he can bill for the first time, when it will be a follow-up visit. These things change on a periodic basis, without that information being communicated to the provider. The service rendered by the factoring company since he is looking to protect his investment, is to make sure those bills are properly executed and in compliance with what the local government authority then wants.

But in addition to the business or the doctor provider, you must take into account the service provider, the ambulance company, the laboratory, the surgical supply dealer and the pharmacy. These people have a tremendous cost investment in goods.

The pharmacy in New York or the pharmacist pays a service charge over and above the cost of his goods which amounts in New York to $1.90 for filing a prescription. If the drug that the doctor has written a prescription for costs him $20, he bills Government $21.90.

If it costs him $1, he bills Government for $2.90. That pharmacist cannot afford to carry that investment for a period of 4 to 6 months. We are not making up figures because these figures cannot be doctored.

Mr. CARTER. They can afford to carry it as well as you can. It will cost them more if they go through you than if they do it themselves. They lose, as you admit, 7 to 10 percent.

Mr. DOCHTER. That is correct, but they have made that determination because they cannot borrow against those receivables from a bank. They cannot borrow from anyone. That is what caused the problem. In any State—and the reports have shown—where payments are made from 15 to 30 days there are no factoring companies.

Mr. CARTER. I think, Mr. Chairman, it goes on in many cases—both pharmacists and physicians in other States go along 10 to 15 days Perhaps licensure or bonding, would be desirable for the factors

Mr. ROGERS. As I understand it, the department has issued regulations prohibiting factoring; have they not?

Mr. DOCHTER. That is correct, sir.

Mr. ROGERS. I do not really know why it was put into the law on the Senate side if it is already being considered by HEW. As I understand, they started in February to get comments and they have now issued final regulations which prohibit factoring.

Were you allowed to make comment?

Mr. DOCHTER. Yes, we were, sir.

Mr. ROGERS. Did you make comment?

Mr. DOCHTER. Yes, we did, sir.

Mr. ROGERS. Thank you very much for your presence here, today. Your testimony has been most helpful and we are grateful to you for bearing with us and staying through the afternoon. Thank you.

Our next witness is Mr. Paul M. Allen, representing the American Public Welfare Association. He is the chief deputy director of the Michigan Department of Social Services.

Mr. Allen, we welcome you to the committee. Your statement will be made a part of the record in full [see p. 27] and if you could highlight it for us it would be helpful to the committee.

STATEMENT OF PAUL M. ALLEN, CHIEF DEPUTY DIRECTOR, MICHIGAN DEPARTMENT OF SOCIAL SERVICES; ALSO ON BEHALF OF THE AMERICAN PUBLIC WELFARE ASSOCIATION, NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS

Mr. ALLEN. Thank you, Mr. Chairman. This statement was written rather hurriedly this morning. I came in from Lansing late last night, but I really could not miss the opportunity of speaking before your group because I thought maybe you ought to hear a success story in this area because we have one in Michigan.

Mr. ROGERS. That would be welcome.

Mr. ALLEN. Michigan has one of the largest medicaid programs in this country. Our expenditures in the next fiscal year will approximate $850 million in State and Federal money just for medicaid. That is 5 percent of the national total.

One out of every $20 in medicaid is going to be spent in Michigan. In the past 3 years we have recouped through our investigative efforts something approximating $4 million from providers who have been identified as abusing the program. We currently have under indictment several physicians who have, we suspect, frauded the program.

I am going to testify in Detroit court against two of those physicians who were so indicted.

The basic problem in this whole business is the sheer volume of information that a medicaid manager has to cope with. Further, if you

have a physician involved in the process of peer review, even a PSRO, there is a tremendous volume of information that has to be sifted through, evaluated, and identified before we can specify cases bordering on fraud or in that fuzzy area we call abuse.

In Michigan, we get 30 million medicaid claims a year. Thirty million a year. The State is its own fiscal intermediary. We took that over from Blue Cross and Blue Shield in 1972. We have an approved medicaid management information system (MMIS) in existence for which we get 75 percent Federal match.

We are one of the few States that have MMIS, and we are the largest State in the Union that acts as its own intermediary. It is because we have this MMIS which is the acronym for medicaid management information system, that we can continue what we consider to be a successful fraud and abuse investigation effort.

The basic information on which peers make decisions and on which administrators identify fraud and abuse is this torrent of data that flows in on billing forms. Who are the providers, who are the clients, what do they do, what are their rates?

How frequently are they servicing our clients? Are chiropractors doing brain surgery, are laboratories billing for prescriptions that never were issued? Information on these kinds of things only flows into the system through a billing process. As you are now aware I had to change my whole pitch here because I have been sitting here all day listening and I am really shocked at some of the things I have heard.

I know it is bad out there, but I did not realize how bad. Medicaid payment and review processes are elsewhere. Our average payment process for 85 percent of the physicians' bills is 15 days or less. And that is still while identifying fraud and abuse through the back end of the system.

Mr. ROGERS. That 85 percent——

Mr. ALLEN. Eighty-five percent of our physicians' bills are paid in 15 days or less.

Mr. ROGERS. What is the longest time?

Mr. ALLEN. There is always a few old dogs that will hang around the system. The longest time is probably 110 days, but that is one claim out of 10,000. However, 99 percent of the bills are paid within 30 days. We have no factoring problem. Last year I testified before Senator Moss' committee and Senator Percy also and, of course, they were very interested in our approach because factoring was big in Illinois due to problems they have had in payment processes. Senator Percy in particular asked the same questions Dr. Carter did of me.

He said, "What is your factoring problem in Michigan?" I did not even know what factoring was until I got a call from a doctor in Chicago and he said, "Mr. Allen, how many doctors factor in your State?" I said, "What does that mean?" and he explained.

He said his average payment process was something in excess of 5 months. So, therefore, to keep a cash flow he discounted his bills. I said, "We do not do that." And when I told him he said, "I do not understand how you do it. You must be overpaying everybody." And I said, "No, that is not the case."

So the essence of the story is that you have to organize the process to pay bills. You cannot organize it in 50 different States and 3

territories the same way over night. It is a very difficult process. But you also have to have a commitment that you want to do this, too.

In Michigan, it was such a legislative hassle a couple of years ago, the medicaid mess, that our State leigslature said, "We are going to invest in a better way to do this and we are going to insist it be done that way." And that is what we have done.

Mr. ROGERS. How many employees do you have?

Mr. ALLEN. Total employees in the medicaid process at the present time is roughly 380. Now, these are not involved in bill payment only. Out the back end of the payment system comes a surveillance and utilization review system. And what it does it tracks doctors, pharmacists, hospitals and establishes a pattern or profile.

It says, "This doctor is outside of normal limits. He sees the same patient frequently. He prescribes two drugs every time he sees a patient. He requires 14 tests every time a patient is seen." That kind of thing. On the basis of these observations you can go out with an investigative unit and enlist the support of doctors and PSRO's to identify abuse and bring these people to task.

Mr. ROGERS. Have you discussed this with HEW?

Mr. ALLEN. Yes.

Mr. ROGERS. What reaction have you received?

Mr. ALLEN. We get a constant stream of visitors

Mr. ROGERS. Have you seen any reaction?

Mr. ALLEN. Yes, I have seen some. I know in the State of California, for example, where they use a contractor to do it the contractor came and saw us and adjusted the California system to emulate ours. If you want some personal suggestions in this area, if you are going to make a nationwide improvement I would suggest that maybe what we need is 10 or so MMIS centers nationwide much like the Internal Revenue Service has 10 centers for handling tax returns. These centers could be under Federal control and process all the bills for the contiguous States and then feed out the back end some utilization review data to the States that says, "These things do not look right in your State for these doctors and these pharmacists, et cetera." Using these data, States working with PSRO's, can close the loop by getting the recalcitrants in line and shaping this thing up.

Mr. ROGERS. I think your experience is most helpful to the committee. I would like to have staff keep in touch with you and get some suggestions that may be applied nationwide.

Mr. ALLEN. All right. I would like to make one more point. The medicare system does not have an MMIS. But the problem there is almost the same, and I say almost because under medicare the patient can pay for the bill instead of the bill being sent to a central unit for payment. But the principal of utilization review, investigation, the whole concept pertains to medicare just as well as they do to medicaid.

[Mr. Allen's prepared statement follows:]

STATEMENT OF PAUL M. ALLEN, CHIEF DEPUTY DIRECTOR, MICHIGAN DEPARTMENT OF SOCIAL SERVICES; ALSO ON BEHALF OF THE AMERICAN PUBLIC WELFARE ASSOCIATION, NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS

Mr. Chairman and Members of the Committee, I wish to thank you for the opportunity to testify on amendments to H.R. 12961. I am Paul Allen, Chief Deputy Director, Michigan Department of Social Services. I am here to speak on behalf of the American Public Welfare Association, National Council of State Public Welfare Administrators as well as the State of Michigan.

Michigan has one of the largest Medicaid programs in the country and represents 5% of all Federal and state Medicaid expenditures annually. In the next fiscal year, our Medicaid budget is projected in excess of $800 million, half of which is Federal funds. Because of the magnitude of our involvement in the Medicaid program, we have actively participated in other Congressional reviews related to all programmatic and administrative aspects of health care legislation. For example, we are one of the few states in the country that has an operational and federally approved Medicaid Management Information System. In addition, we have testified before Senators Moss and Percy with respect to our successful efforts in curbing fraud and abuse in the Michigan Medicaid program. The major thrust of this testimony concerned the use of utilization review information derived from the MMIS system in identifying those Medicaid providers with abnormal patterns and profiles of practice. Because of our concern in these areas, we are pleased to see the renewed Congressional emphasis on identifying the problem areas and facilitating the activities of HEW and states in addressing these issues. The National Council of State Public Welfare Administrators has earlier this year indicated its support for the proposals of Senator Talmadge (S. 3205) regarding Medicaid and Medicare fraud and abuse.

Both the National Council of State Public Welfare Administrators and the State of Michigan support the intent of several of the amendments to H.R. 12961 concerning improved coordination and direction of policy regarding fraud and abuse and Medicaid. However, we do have some reservations in the following areas.

First, with regard to the establishment of a central office of fraud and abuse for both Medicare and Medicaid, we believe that combining these very large administrative entities may degrade the capabilities of both programs.

Second, our most serious reservation is that section of the amendments which more explicitly strengthen the role of PSROs in reviewing and making final determinations with respect to Medicare and Medicaid issues. The problem here is that PSROs have by their structure a very limited perspective of utilization of health care services. In the State of Michigan we have 10 designated PSRO geographical areas. Two of these areas have operational (conditional) PSROs. Neither of these organizations has at its disposal a utilization review program that approaches the quality and comprehensiveness of the operational MMIS program in Michigan. Further, if these PSROs did develop such a utilization review capability, they could only apply their findings to their own geographical sphere of influence. This fragmented method of operation will not achieve the desired objective of providing the appropriate program manager an effective and equitable utilization review mechanism. If, as the amendments propose, PSROs are given additional program responsibility this will further exacerbate this already existing problem. We, therefore, recommend that this section be deleted.

As a final, but very important point, I wish to emphasize that in Michigan we do not believe that fraud and abuse are the prime contributors to soaring health care and thus Medicaid costs. Our experience has proved conclusively that the principal culprits are over utilization in both ambulatory and institutional settings and the rapidly escalating unit cost of services. In particular, since 70% of our Medicaid dollars are spent in an institutional setting, we are finding it impossible to live with a very loosely defined concept which requires reimbursement at "reasonable cost."

We in Michigan are continuing every effort to curb fraud and abuse in Medicaid. In this regard we have almost doubled our investigative staff from 29 to 45 persons in one year alone. Similar efforts are being pursued by the State Attorney General to increase the number of legal actions in Medicaid fraud. But we firmly believe that these efforts alone will not significantly contain health care costs. Much more comprehensive program reform efforts, particularly in reimbursement, are urgently needed.

We, therefore, recommend that Congress move to address these broader issues as soon as possible.

Mr. Chairman and Members of the Committee, we thank you for the opportunity to express our views.

Mr. ROGERS. Thank you.

Mr. CARTER. Were you formerly with HEW?

Mr. ALLEN. No; I am a retired naval officer. I was hired to head up the computer center in the State of Michigan and then I was selected to be the head of the medicaid program and now I am chief deputy for

the department of social services. Good management is the principle here and a very delicate relationship with the medical profession is also necessary.

Mr. CARTER. What do you think of factoring?

Mr. ALLEN. I guess if I could not get paid I might find some alternate means of getting some cash, so I cannot comment intelligently on that. I just feel that obviously a provider must be willing to settle for less if he could get paid faster, otherwise he would not do it the way he is doing it.

Mr. CARTER. But if they pay as fast as you do——

Mr. ROGERS. It would be no problem.

Let me ask, Why haven't more States used this MMIS when they get 90 percent of start-up and 75 percent——

Mr. ALLEN. Most of the States subcontract their payment processes to an insurance company or the "Blues" or something like that rather than doing it themselves.

Mr. ROGERS. Thank you so much. Your testimony has been most helpful.

Mr. Andy Schneider, staff attorney, national health law program.

Mr. Schneider, we welcome you to the committee and your statement will be made a part of the record in full.

STATEMENT OF ANDY SCHNEIDER, STAFF ATTORNEY, NATIONAL HEALTH LAW PROGRAM

Mr. SCHNEIDER. Mr. Chairman, I did not have a chance to finish the preparation of my testimony, but would like if possible to submit it for the record at a later point [see p. 131].

Mr. ROGERS. Without objection.

If you will just tell us what you think we need to know.

Mr. SCHNEIDER. Thank you, Mr. Chairman.

I am an attorney with the national health law program which is Legal Services Corp.-funded support center based in Los Angeles.

We represent medicaid beneficiaries who are adversely affected by program fraud and program abuse. For our client's program fraud means they don't get any care at all. Program abuse means they may get some care but it is probably bad quality.

In both cases fraud and abuse means the money which is intended for service goes somewhere else. And what has been particularly troublesome to us has been in the past year or 2 many States have cut back on their medicaid programs, on the benefits and eligibility side, but have not taken a close look at how much money they could save by dealing effectively with provider fraud and abuse.

So we are basically in support of the interest of the committee in this kind of problem. Our difficulty is that the particular bill before the committee now, H.R. 15536, will not touch on some of the larger instructional problems in the program that will have to be addressed in order to make it work.

Those kinds of problems we have testified to before this committee on earlier occasions: during the National Health Insurance hearings, and the hearings on health insurance and the unemployed last year. They have to do with lousy program administration, inadequate provider participation in the program, lack of controls and underutilization eligibility standards and things like that.

There is also some sense of frustration here in talking about this bill in that it seems from our own reading of the law in this and in other areas that HEW has a lot of statutory authority to do what it should have been doing. There may be some—there has always been some disagreement between ourselves and the Office of General Counsel for HEW on what legislative authority they do have, but it seems clear to me a lot of the language in this proposed bill would not really be necessary with a more aggressive HEW posture.

There are also some technical drafting problems in H.R. 15536 which are due to the haste with which it was put together and I certainly appreciate the opportunity to provide some input at this point.

Just a couple of major problems that we have with this bill. First of all, the basic thrust at the administrative level is to reorganize HEW and to activate PSRO's in terms of reviewing the quality of care in the ambulatory area. It does not give the States any incentive to crack down on provider fraud and abuse. The question you just raised with the last witness with respect to why shouldn't the States institute MMI programs is relevant. For one reason or another they do not have the incentive to do so.

Now, there are clearly substantial gains to be made from doing so. So we would recommend States be prohibited from cutting back on benefits and eligibility until they have made effective efforts to improve their existing management programs. And only when they have shown that their management of the program has gotten provider fraud and abuse under reasonable control can they consider cutting back on benefits and eligibility.

Our second recommendation has to do with the section in the bill which would amend the PSRO statute to enable PSRO's to request review responsibility in areas with substantial numbers of shared health facilities.

We have some question as to what a shared health facility is. It is also not clear to us that the Secretary of HEW knows where the shared health facilities are or that anybody does. It seems to us it will be entirely appropriate for the Secretary to come through very soon with an inventory of the ambulatory care service and practitioners available to medicaid recipients. If he finds what our clients indicate to us is the case, there will be great gaps in the delivery of services and there is going to be a need to think through carefully what to do about making alternatives available to program beneficiaries.

In order to think intelligently about that you need information. Apparently the Secretary does not think he has the authority to get that kind of information. We think he should get that authority.

The third point is closely related to the second. What happens when a shared health care facility is shut down or if you clamp down on the factoring operation? What is the alternative for the beneficiaries?

One proposal that we have is to amend this bill to require the State agencies upon the termination of a shared health care facility to provide notice to beneficiaries that have been using the service of that facility as to where else they might go to get service covered under the plan. I don't know how administratively feasible that is for those States which don't have their programs together, but we have talked about that before.

The other recommendation I had not intended to proffer. But since it was brought up by Mr. Preyer, I will. And that is to take the money that is saved by controls on provider fraud and abuse and recapture it to build up ambulatory care resources in the area where shared health facilities now operate, I have drafted some language to that effect in a proposal along those lines, which I could make available to the committee for its consideration.

Another point of criticism here is that if shared health facilities which are now receiving payment are denied payment or for one or another reason closed down, it is possible that either their assignees or the facilities themselves, or the providers associated with the facilities will go after our clients for collection of the claims which the State or Federal agencies or PSRO's deny them.

We would like statutory protection for our clients in the form of a prohibition against the prosecution of claims for collection against eligible beneficiaries.

In sum, those are the general problems that are not addressed by the legislation that we would like to see some amendments on.

I have some other comments on what is in the bill that could require some improvement.

Mr. Rogers. We will be glad for you to get with the staff and give them your suggestions. I think it would be helpful.

Thank you so much for your presence and for your helpful suggestions, Mr. Schneider.

Mr. Schneider. Thank you.

[Testimony resumes on p. 136.]

[Mr. Schneider's prepared statement and appendixes were received for the record:]

STATEMENT OF ANDY SCHNEIDER, STAFF ATTORNEY, THE NATIONAL HEALTH LAW PROGRAM

Mr. Chairman and members of the subcommittee: My name is Andy Schneider. I am a staff attorney with the National Health Law Program, a Legal Services Corporation-funded support center based in Los Angeles, California. Since 1969, we have provided technical and litigation assistance to local legal services attorneys throughout the country in an effort to resolve the difficulties their low-income clients have encountered in obtaining needed health care services. NHeLP is currently representing Medicaid beneficiaries who are being, or have in the past been, adversely affected by provider fraud and abuse in the program of the kind which the bills now before the Subcommittee address. This statement is confined to H.R. 15536 since time limitations precluded any adequate analysis of either H.R. 14805 or H.R. 15390.

INTEREST OF PROGRAM BENEFICIARIES

As beneficiaries of the Medicaid program, our clients have a direct and obvious interest in effective governmental control and prevention of fraud and abuse by participating providers. Provider fraud—intentional billing for services not rendered or billing for more expensive services than those actually rendered—means that program eligibles get no care whatsoever. Provider abuse—over-utilization of services, ping-ponging, gang visits, shorting, and overcharging—means that program eligibles get inferior quality and/or unnecessary care. In both instances, scarce federal and state dollars intended for badly needed services are siphoned off for other, illegitimate uses. (Even DHEW acknowledges that the losses arrtibutable to provider fraud and abuse could represent between 5 to 10 percent of total Medicaid expenditures.)

Financially-pressed states, looking for ways to contain the increase in their Medicaid expenditures, have tended to cut back on benefits and eligibility rather

than trying to assure that the services for which they are paying have actually been delivered and, if so, whether the services were medically necessary. In light of the evidence amassed by various Congressional committees on the extent of provider fraud and abuse, a cost containment policy which relies on punishing beneficiaries to reduce outlays while ignoring waste by providers is unconscionable. We are greatly encouraged that this Subcommittee and other members of Congress have recognized the problem and are attempting to find a solution. We also appreciate the opportunity to express our views on what solutions might be most effective from the standpoint of program beneficiaries and taxpayers, who shares a common interest in eliminating provider fraud and abuse in the Medicaid program.

STATEMENT OF THE PROBLEM

It is difficult to discuss legislative or administrative solutions without understanding the problem. As a result of a report issued by the staff of the Subcommittee on Long-term Care of the Senate Special Committee on Aging, fraud and abuse by fee-for-service practitioners participating in Medicaid have received a good deal of publicity recently. Yet fraud and abuse, while of major concern in and of themselves, are also symptomatic of larger structural problems in the Medicaid program. In our testimony before this Subcommittee on February 4th of this year in connection with its hearings on national health insurance, we outlined some of those structural problems and their implications for our clients, including poor program administration and management, inadequate provider participation, and failure to contain overutilization or prevent underutilization by providers. The measures proposed by H.R. 15536—creation of an office of fraud and abuse control within DHEW, authorization for PSRO review of ambulatory care providers, improved disclosure requirements for participating providers, prohibition of assignment of claims by physicians to factoring firms, and increased penalties for fraud and abuse—may and hopefully will reduce the incidence of fraud and abuse. However, they do not address and will not solve the larger structural problems that are causing the collapse of the program.

There is, in addition, a serious question whether even a short-run solution to provider fraud and abuse requires new legislation or simply more conscientious implementation of existing legislative authority by DHEW. As the Senate Special Committee on Aging Staff Report makes clear, the existence of provider fraud and abuse has been known to responsible federal and state agencies for many years. Yet until Congressional pressure was applied, DHEW did little about the problem. Only recently has DHEW begun to increase its investigatory staff and tighten up its applicable regulations.[1]

With scheduled adjournment fast approaching, there is plainly no time to consider long-term reform of the Medicaid program that is in the best interests of beneficiaries and taxpayers and is acceptable to most providers. We urge the Subcommittee to take up this matter at the earliest opportunity next session before additional cutbacks by states further decimate what is left of the program. While we have reservations about the need for short-term anti-fraud and abuse legislation, H.R. 15536 could contribute to the solution of the underlying structural problems if amended as suggested below.

RECOMMENDATIONS

(1) H.R. 15536 would attack provider fraud and abuse in Medicare and Medicaid by reorganizing DHEW's anti-fraud resources, increasing the sanctions applicable to such provider activity, and promoting PSRO review of Medicaid mills. In doing so, the bill seems to ignore a central characteristic of Medicaid: it is a program administered by the states within federal guidelines. If provider fraud and abuse is to be reduced to acceptable levels, then the state Title XIX agencies and their fiscal agents will have to play a central role. Yet with few exceptions, state Title XIX agencies have been unwilling to crack down on provider fraud and abuse or incapable of doing so. Instead, the states have responded to rising program expenditures by cutting back on benefits and eligibility. H.R. 15536 offers no incentive for the states to take any meaningful action against fraud and abuse. Accordingly, we propose that the bill be amended to prohibit states from cutting back on benefits or eligibility unless they have demonstrated to the satisfaction of the Secretary that they have taken all reasonable and necessary

[1] See, *e.g.*, the amendments to 45 C.F.R. § 249.31 at 41 *Fed. Reg.* 36207 (August 27, 1976).

measures to detect and prevent provider fraud and abuse, including the installation and operation of a Medicaid management information system (MMIS). The savings flowing from substantial reductions in fraud and abuse could well obviate the need for benefits or eligibility cutbacks, at least in the short run. Legislative language reflecting this proposal may be found in Appendix I.

(2) H.R. 15536 targets Medicaid mills, defined as "shared health facilities," for special attention by federal authorities and PSROs. Given the inferior care and financial waste associated with many of these mills, this emphasis seems appropriate. Yet many Medicaid beneficiaries seek care from these mills because they are the only accessible source of ambulatory care. If federal, state, and PSRO anti-fraud and abuse activities result in the closure of these mills, where will program beneficiaries in need of ambulatory care turn? H.R. 15536 is silent on this crucial point.

It is neither humane nor responsible to legislate against provider fraud and abuse without at the same time promoting the development of alternative sources of high quality ambulatory care. We propose that the money saved by curbing fraud and abuse be recaptured for the development of ambulatory care services in those urban areas where Medicaid mills currently flourish as well as those rural areas where few if any providers participate in the program at all. This might be done by channelling the Medicaid "savings" to Health Systems Development Funds for the development of ambulatory care services to Medicaid beneficiaries and other poor people residing in medically underserved areas. Since the Congressional Budget Office has estimated that fraud in the Medicaid program accounts for $100 million of program outlays, and since the federal government will spend some $10 billion on Medicaid in FY 1977, it seems reasonable to place the savings attributable to fraud and abuse control at one percent of federal Medicaid outlays. A proposed amendment to H.R. 15536 to this effect is attached hereto as Appendix II.

In the short run, it will often not be possible to establish new sources of ambulatory care. Instead, program eligibles currently receiving services from Medicaid mills that are closed down for fraud and abuse will have to make do with what limited resources exist in their communities. In order to seek out alternative providers, however, beneficiaries will have to know where they are located. Accordingly, we propose that the Social Security Act be amended to require state Title XIX agencies to notify eligible persons who received services from mills and other providers that have ceased participating in the program of the names and addresses of participating providers in or near their communities. Language incorporating this suggestion is set forth in Appendix IV as proposed §1902(a)(37)(C).

(3) If H.R. 15536 is enacted and if DHEW sees fit to implement it, then many of the claims for payment submitted by providers affiliated with Medicaid mills, or by their assignees, are likely to be denied by the state Title XIX agency or fiscal agent, as the case may be. Based on the experience of Medi-Cal beneficiaries with terminations of Prepaid Health Plan contracts in California, we believe it highly likely that some of the providers and assignees will attempt to secure payment for services allegedly or actually rendered directly from Medicaid beneficiaries. Although current law, in our view, provides a complete defense to any such collection action, it appears that some providers have not been willing to acknowledge that eligible persons are not liable to them for covered services. This suggests that statutory and regulatory clarifications of this point is in order. The statutory language set forth in Appendix II Iwould reaffirm this federal policy.

(4) As argued above, provider fraud and abuse have roots in larger structural defects in the Medicaid program. Chief among these is the absence of any effective policy to make necessary ambulatory services of high quality available and accessible to program eligibles. In order to formulate and implement such a policy, Congress, DHEW, and the public need more information about the actual availability of ambulatory care services under Medicaid. For example, Section 6(a)(2) of the bill instructs the Secretary to give priority to PSRO requests to conduct reviews of ambulatory care services in "areas with substantial numbers of shared health facilities." Yet there is no evidence that the Secretary (or many of the states) knows precisely where those areas are and what the alternative sources of ambulatory care, if any, might be. We therefore recommend that Congress require the state Title XIX agencies to inventory the ambulatory care providers participating in Medicaid and to identify those areas with high concentrations of mills. A suggested statutory provision along these lines appears in Appendix IV.

(5) Section 4 of H.R. 15536, which requires the disclosure of financial and ownership information by Medicaid providers to DHEW or GAO, does not go far enough. While it gives federal authorities the authority to request information necessary to detect provider fraud and abuse, it does nothing to assure that all the necessary information will be available or, if it is available, that it will be in a form that permits program officials to compare the performance of one provider with another at the same point in time or to compare the performance of the same provider at different points in time. This dictates two additions to Section 4: a requirement that Medicaid providers maintain uniform financial and statistical reporting systems employing common definitions, and that providers file such information (including but not limited to "consolidated certified cost reports") periodically with the State agency.

The detection of provider fraud and abuse in delivering ambulatory care services is a subset of a larger problem: the assessment of ambulatory care costs and utilization generally. Federal and state agencies are currently severely handicapped by the lack of a uniform financial and statistical reporting system and by the failure to link financial accounting to patient utilization data when attempting to gauge performance efficiency. In order to make valid assessments among ambulatory care providers with respect to their charges or utilization patterns, the data relied upon must follow common definitions and be uniformly reported around common types of activities, i.e., according to functional accounting centers. We recognize that the implementation of such a reporting system would face considerable technical obstacles; however, we feel these can be overcome and that the Secretary should be expressly authorized and required to develop and implement such a data base and reporting system by fiscal year 1978.

Even if the more limited purpose of Section 4 is to be accomplished, then some tightening up of the current language will be necessary. First, the term "provider or supplier of items or services" should be defined; otherwise we would anticipate a good deal of time-consuming litigation concerning the scope of the Secretary's or GAO's authority to obtain information. Second, the definition of the term "shared health facilities" is in need of considerable clarification; as currently drafted, it is extremely difficult to determine exactly what entity or practitioners would fall within this category. Third, the language of proposed Section 1132(a)(1)(C) should be amended to make clear that the obligation to disclose the requested information applies not only to entities which furnish (or arrange for the furnishing of) Medicaid services, but also to any subcontractors or affiliated providers or suppliers to whom Title XIX monies flow, directly or indirectly. In the absence of clear language on this point, providers are likely to follow the lead of some Prepaid Health Plans in California by establishing shell corporations for disclosure purposes and conducting business out of subcontractors insulated from the investigatory efforts of public agencies.

(6) H.R. 15536 does not adequately address the problem of bad quality care associated with Medicaid mills. It would trigger PSRO review of the necessity, quality and appropriateness of ambulatory services delivered by Medicaid mills and other practitioners only if the PSRO requested the authority to conduct such reviews and if the Secretary certified the PSRO as capable of undertaking such reviews in an ambulatory care setting. Since so few PSROs are operational now, and since so few of those have the capability to conduct such reviews in an ambulatory care setting, it is highly unlikely that the quality of ambulatory care services received by medicaid eligibles in or out of mills will receive any significant regulatory attention in the next year or two. Accordingly, we urge that the Congress not rely exclusively on the exercise of discretionary (and, when undertaken, conclusive) review authority by PSROs. Instead, the Secretary should be authorized and required to assist states in conducting medical audits of shared health facilities and other high volume providers. This could be done by the use of federal medical audit teams, similar to the financial audit teams which DHEW has already sent to certain states.

Finally, Section 6(e) of the bill, concerning the disclosure of data and information by PSROs to responsible state and federal agencies, should be clarified to assure that these agencies have no difficulty obtaining any information needed in connection with the detection and prevention of fraud and abuse, including the profiles and reports generated by PSROs pursuant to Sections 1155(a)(3), (4), and 1157 of the Social Security Act. Furthermore, this data (as well as financial and ownership information discussed above) should be accessible to the public. As the history of H.R. 15536 itself makes clear, only when the fraudulent and abusive practices of Medicaid providers are made known to the public

will Congress, DHEW or the states feel sufficiently pressured to take remedial action. Without access to the data and information generated by the PSROs, investigative journalists and concerned citizens will be unable to monitor the performance of DHEW, the states, or the Medicaid vendors. And in the absence of such independent scrutiny, the prospects for effective control of fraud and abuse in the long run are dim.

CONCLUSION

In summary, we would like to thank the Subcommittee for the opportunity to comment on H.R. 15536. If legislation is indeed necessary to induce the Secretary to take effective action to curb fraud and abuse, this bill will require considerable revision to effectively serve the interests of program beneficiaries and taxpayers. Regardless of the final disposition of this measure, we urge the Subcommittee to take up the matter of structural program reform at its earliest convenience during the next session. If you or the members or staff of the Subcommittee have any questions concerning our recommendations, I would be pleased to respond.

Appendix I

Amendment to H.R. 15536

PROVISION TO ENCOURAGE STATES PARTICIPATING IN MEDICAID TO TAKE EFFECTIVE ADMINISTRATIVE MEASURES TO DETECT AND PREVENT FRAUD AND ABUSE

Sec. 8. Section 1902 of the Social Security Act is amended by adding at the end thereof the following new section:

(h) Notwithstanding subsection (b), the Secretary shall not approve any change or amendment proposed to any State plan for medical assistance in effect on September 30, 1976, that would be likely to have the effect of (1) reducing the numbers or categories of individuals eligible for medical assistance under such plan or (2) reducing the types of care and services included under such plan, or the amount, scope, or duration of such care and services, unless the Secretary has, after consulting with the appropriate Medical Care Advisory Committee, made a determination that the single State agency administering or supervising the administration of such plan has taken all measures necessary to detect and prevent fraud and abuse by providers or suppliers that furnish, or arrange for the furnishing of, items or services with respect to which payment is claimed under such State plan, including, but not limited to, the installation and operation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan.

Appendix II

Amendment to H.R. 15536

PROVISION TO ASSURE CONTINUITY OF AMBULATORY CARE TO PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE

Section 7(a). Section 1903 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(m)(1) Notwithstanding any other provisions of this section, the Secretary shall, for each fiscal year, beginning after September 30, 1977, make to each health systems agency designated by the Secretary pursuant to section 1515(c) of the Public Health Service Act which is determined by the Secretary to contain within its health service area medically underserved populations (as determined by the Secretary pursuant to section 1622(16) of the Public Health Service Act) residing in urban or rural poverty areas (as defined by the Secretary pursuant to section 1633(15) of the Public Health Service Act) a grant to enable such health systems agency to make grants and enter into contracts from its Area Health Services Development Fund for the planning, development or expansion of ambulatory care services pursuant to section 1640(e) of the Public Health Service Act.

"(2) The amounts payable by the Secretary under grants under paragraph (1) in any fiscal year shall be equal to 1 percentum of the total sums expended as the Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act) during the prior fiscal year.

"(3) Of the sums payable each fiscal year under paragraph (2), the amounts payable to each health systems agency pursuant to paragraph (1) shall be the proportion of the total of such funds available pursuant to paragraph (2) equal to the ratio of (i) the medical assistance payments during the prior fiscal year made in the health systems agency's health service area to (ii) the total amount of medical assistance payments in the United States for such fiscal year."

(b) Section 1640 of the Public Health Service Act is amended by adding at the end thereof the following new subsection:

"(e) A health systems agency shall expend amounts received from grants made by the Secretary pursuant to section 1901(m)(1) of the Social Security Act exclusively for the planning, development, or expansion, by grant or contract, of projects or programs (including health maintenance organizations as defined in section 1301 and community health centers as defined in section 330) which (i) are, or will be when operational, qualified to participate as a provider of services under title XIX of the Social Security Act and (ii) deliver, or will deliver when operational, ambulatory care services to medically underserved populations residing in urban or rural poverty areas.

Appendix III

Amendment to H.R. 15536

PROVISION TO PROTECT MEDICAID RECIPIENTS FROM COLLECTION EFFORTS BY SHARED HEALTH FACILITIES

Section 7. Section 1902(a) of the Social Security Act is amended by adding thereto the following new paragraph:

(37) provide that any individual who has been determined to be eligible for medical assistance under the plan shall not be liable to any provider or supplier of items or services (including a shared health facility as defined in section 1125 and any other provider or supplier affiliated or contracting with such a facility), or to any agent or assignee of such provider or supplier, for any charges or costs in connection with the provision of care and services included under such plan, other than enrollment fees, premiums, deductibles, cost-sharing, or similar charges imposed by an approved State plan in accordance with paragraph (14);

Appendix IV

Amendment to H.R. 15536

PROVISION TO REQUIRE STATES PARTICIPATING IN MEDICAID TO INVENTORY AMBULATORY CARE PROVIDERS, TO IDENTIFY AREAS WHERE SHARED HEALTH FACILITIES ARE CONCENTRATED, AND TO NOTIFY RECEIPIENTS OF ALTERNATIVE SOURCES OF SERVICES

Sec. 9. Section 1902(a) of the Social Security Act is amended by adding thereto the following new paragraph:

(37) provide that the single State agency administering or supervising the administration of the plan shall (A) no less frequently than once each year beginning September 30, 1976, survey and inventory, by type of care and service provided and by geographic area, the providers and suppliers that furnish, or arrange for the furnishing of, items or services with respect to which payment is claimed under such plan, (B) make reports to the Secretary, in such form as the Secretary shall prescribe, setting forth the findings of such surveys and inventories and identifying those areas characterized by the presence of a substantial number of shared health facilities (as defined in section 1125), and (C) within 30 days of the termination or discontinuation of participation under the State plan by a provider or supplier of items or services, shall notify those recipients of medical assistance who had received care or services included under the plan from such providers or suppliers (including a shared health facility as defined in section 1125) of the names and locations of accessible providers or suppliers participating under such plan.

Mr. Rogers. The next witness is Mr. Victor L. Schwartz, attorney at law, the former assistant U.S. attorney of the eastern district of Pennsylvania, Philadelphia.

We welcome you, Mr. Schwartz. We are sorry we are so late in getting to you.

STATEMENT OF VICTOR L. SCHWARTZ, ATTORNEY, FORMER ASSISTANT U.S. ATTORNEY FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Mr. SCHWARTZ. Because of the lateness of the hour I will be brief. I want, however, to make a preliminary statement. I believe I have maybe a unique—and if not unique, certainly a highly unusual—privilege and honor to speak before this committee of Congress about pending legislation, of which I did not even know was pending. I was requested only yesterday to come down and appear and it is my privilege to do so.

I understand before I arrived this morning that someone stated there was not much fraud in the medicare program. There is no question that the fraud in medicaid is much greater than in Medicare but there is a great deal of fraud in medicare. In the last 2½ years as a prosecutor—I just resigned in June of this year—I specialized in the prosecution of physician fraud, including physicians who were convicted under mail fraud statutes for defrauding Pennsylvania Blue Shield in its regular business.

A July 29 article of the Washington Post quoted Senator Moss about convictions of physicians. The figures he was using I am positive were March 31, 1976 figures provided him by HEW as I believe I have a set of these statistics.

Senator Moss was quoted on July 29, as stating that 150 physicians have been convicted of fraud in the last 5 years. Of that only 14 were sent to prison. At that time 20 percent of those convictions were out of the Eastern District of Pennsylvania, one of 94 or 96 U.S. attorneys' offices. Since that time I obtained, before I resigned, three convictions. One additional person was a fugitive on the day of trail September 3, 1975. He has been found and has pleaded guilty and has been convicted and was sentenced. Since that time four of those——

Mr. ROGERS. Where was he practicing medicine?

Mr. SCHWARTZ. He was not practicing medicine. I think he had run away to Canada. Senator Moss was quoted as saying that, as I stated before, only 14 had gone to prison. Again he was using March 31 statistics.

Since that time four more additional physicians have been sent to prison from the eastern district. I say immodestly than nine had been cases that I personally prosecuted.

I find it astonishing that one U.S. attorney's office would have approximately 20 percent of all the convictions in the county.

One assistant U.S. attorney out of 1,500 would have two-thirds of those convictions—and half of all of those in 10 years. I was only prosecuting physicians for 2½ years—yet prosecuted half of all those that went to prison. That states something.

I think it is incredible that 20 percent of all the physicians who are committing fraud are in the Philadelphia area. That is nonsense. It is nonsense on its face, and we can't debate it.

What it states is that program and integrity specialists of the Bureau of Health Insurance don't know how to uncover the fraud, certainly with the exception of the Philadelphia regional office, and they need investigatory direction. U.S. attorneys do not have the experience to prosecute these cases and until last year they did not

understand the implication of the cases. HEW would come in with a case of fraud of maybe $2,000 and it was "mishmash," and so forth. The U.S. attorney would not consider it a big case and would decline it.

You may have an 85 count indictment—and this is an actual experience—$3,000 worth of fraud and defense counsel says, "This is a minor case, Your Honor." I knew from the scope of the investigation that we were only looking at a microcosm and by projection there had to be at least $100,000 of fraud and we actually proved that. We asked Pennsylvania Blue Shield to pull out all the claims submitted in 5 years. We did not go to trial and prove this but we proved it to our satisfaction and showed that where HEW came up with a case of $3,000 our projections were exactly on point. We figured it was about $100,000. That is what we came up with.

I could talk ad infinitum as I believe Miss Nelson suspects. Because you are here for a specific purpose, I don't intend to do so. And I will just make some comments in regard to the bill.

I only looked at the bill this morning. By the way, one of the criticisms I had was medicaid and medicare kickback provisions was so poorly written that they failed to cover half of the potential problems. I see you attempted to correct that in section 204 where you add the words—before it was merely the individual who had provided or furnished the service—and now you have added "who arranges for the furnishing of * * *."

I had no idea you intended to vote on this bill today. I was trying hard to think of some language which would possibly amplify that. I unfortunately cannot because I was trying to listen to the testimony and I heard some good testimony. I understand that the provision attempts to make a person who is involved in criminal practice—the one who refers a recipient of the service or the landlord, or so forth—I think it will serve its purpose but it does raise an issue. Although I don't have any better language as a lawyer, and now I am hopeful, as someone who represents doctors on the other side—I would say that language is too vague. Although legislation must be construed for its purpose, a more overriding dictum of legislative construction is that criminal statutes must be strictly construed.

I think the court of appeals would say the provision embraces someone who refers the patient. It is however an issue that counsel is going to raise—that it is too vague and it is unconstitutional. You can't convict someone on vague criminal statutes.

One other comment in regard to the bill on a provision which is not included and maybe should be—and that is, that the States should be required when they suspect—and certainly when they have determined that fraud is committed—that the case be referred to the U.S. attorney's office.

Even those States which have attempted to effectively police the medicaid program have tended to settle the cases like automobile accidents. Naturally if I were representing a physician the last thing I would want him to do would be to be prosecuted. Truthfully, the only real deterrent is criminal prosecution where appropriate and for some reason I believe Pennsylvania is representative of all of the States. When they have found fraud they have not prosecuted. Whether it is for politics or cronyism or incompetence or just sheer

laziness, I don't know. In addition to those reasons I think it is obvious to all of us in this room that the level of competency at the Federal level is much better and Federal prosecutors have the tools of grand juries which local prosecutors do not tend to have.

For those reasons I believe that that possibly should be a requirement. They just don't do that.

Mr. ROGERS. Thank you so much, Mr. Schwartz. If you have any specific suggestions that come to mind we would welcome them, because we will still be able to bring legislation to the floor.

Mr. SCHWARTZ. On this particular bill?

Mr. ROGERS. Yes. I think it would be helpful and any discussions you may want to have with staff on this I welcome.

Mr. SCHWARTZ. When are you going to vote on it, today?

Mr. ROGERS. It would be on the floor next week, we hope.

Thank you for your help and congratulations onthe good work you did.

Mr. SCHWARTZ. Thank you, sir.

Mr. ROGERS. Our last witness is Mr. John F. Horty, president of the Council of Community Hospitals, Pittsburgh, Pa.

Mr. Horty, we welcome you to the committee, and we apologize for getting you on so late. Your statement will be made a part of the record in full [see p. 140], and if you will, tell the committee the highlights of what we need to hear.

STATEMENT OF JOHN F. HORTY, PRESIDENT, COUNCIL OF COMMUNITY HOSPITALS

Mr. HORTY. Thank you, Mr. Chairman.

I am president of the Council of Community Hospitals, a group of nonprofit hospitals located throughout the country. Basically, the point which we wish to make to the committee is our concern with section D of the pending bill, particularly paragraph (d) of proposed section 1132. This section deals with the requests by the Secretary or by the GAO for as "full and complete" information as to "any business dealings" between hospitals and directors and officers of such hospitals.

The language of this section encourages what we see as fishing expeditions into transactions and dealings in nonprofit hospitals which are likely to produce unnecessary embarrassment, and uncertainty not really intended by this act. We have language here which we would like to have added to the section to clarify its intent.

Mr. ROGERS. We will be glad to look at that.

Mr. HORTY. This language would basically have the effect of saying that if a hospital had a policy of the Board to deal with conflicts of interest, as well as a method of handling such transactions that was open and realistic, evidence of this would comply with the section.

If they had a policy and if they memoralized the transactions in open board minutes, as being openly considered by the Board. that this would constitute compliance with this section when a request was made. This puts basically a workable and certain limitation around the necessity to produce information. And I would also point out to the committee that there is, at present, HEW closely audits nonprofit hospitals as to officer and director transactions, anyway, so in

a sense the entire section is a duplication, so far as nonprofit hospitals are concerned.

I don't think anyone is contending that the audit of a nonprofit hospital isn't an effective audit at the present time.

At the same time nonprofit hospitals as, charitable corporations make similar information available by filing a form 999 with the Internal Revenue Service so our concern is not with the intent of the proposed section but with the indefiniteness of this particular paragraph and the language in it, and particularly the term "business dealings," which I, as a lawyer, find difficult to define or to advise a client as to what it constitutes. I would point out one other fact. The lack of clarity in this section may produce some concern on the part of hospitals with respect to electing physicians who are on the medical staff to the board of the hospital, something which the Joint Commission has endorsed and we have endorsed it now would raise some questions about such an action when wide-ranging inquiries were made.

We also propose one other technical amendment, and that would be to limit the information needed to be given as a result of inquiries to 3 years prior to the request, so we do not have an indeterminate period.

We would be happy to work with staff on our proposed amendment.

[Mr. Horty's prepared statement follows:]

STATEMENT OF JOHN F. HORTY, PRESIDENT, COUNCIL OF COMMUNITY HOSPITALS

My name is John F. Horty. I am President of the Council of Community Hospitals, an organization serving the non-profit hospitals that provide hospital care to the thousands of communities across the country. To that end, CCH assesses major Federal legislative proposals that might affect community hospitals and expresses its views on such proposals.

CCH is particularly grateful to the Committee for holding these hearings. As Congressman Rogers so aptly stated in his recent remarks, the provisions of H.R. 15536 are important and should be considered in public hearing. CCH welcomes the opportunity to draw the attention of this Committee to one aspect of the bill. We have come here to talk about proposed Section 1132, a Section that, particularly as passed by the Senate in H.R. 12961, contains loopholes which prevent embarrassment to everyone except the thousands of men and women who without pay and without profit serve as trustees for their and your communities' hospitals.

Section 1132 is a poorly considered provision. This is a deeply held feeling of mine—one based on twenty years of speaking before trustees, talking with them personally, and advising them legally. Trustees all over the country will see this Section as one more attempt by Congress to inhibit and constrain the very people trying to do a good job for their hospitals and as a failure by Congress properly to restrain the malefactor. The net which Section 1132 casts will embarrass and irritate the non-profit volunteer trustees and will do nothing to deter the crook, be he owner, director, trustee, or physician.

In its commendable efforts to curb fraud, proposed Section 1132 goes farther than is necessary to do so and will, at the same time, adversely affect the operation of the thousands of law-abiding community hospitals in this country.

I am referring specifically to the operation of proposed Section 1132(a)(1)(C) and (D), which would authorize the Secretary of HEW and the Comptroller General to require non-profit hospitals, as well as other specified health care entities, to provide "full and complete" information about "business dealings" between the hospital and its officers and directors. HEW already has the necessary authority under the current law, with respect to hospitals and other providers, to review or require the States to review related transactions where the Secretary finds it necessary to do so in order to determine hospital reimbursement. The proposed Section, therefore, does not appear to be necessary insofar as hospitals are concerned.

At the same time, however, proposed Section 1132 would impair the legitimate management of hospitals, particularly non-profit community hospitals.

In an effort to unearth improper transactions between health care entities and related persons, proposed Section 1132 wrongfully makes suspect all proper transactions between related persons. In many communities, transactions between hospitals and local businessmen who serve on hospital boards are a necessity. In almost all of such cases, the transactions are fair and open. In many cases, they are in fact highly beneficial to the hospital. They allow the hospital to gain advantageous prices and better service from a person who is on the board and consequently is aware of and interested in the hospital's problems. The crucial point is not whether such transactions occur but whether they occur openly, on the record, and in the minutes of the board.

This Committee is aware that the vast majority of the thousands of community-minded persons who devote their valuable time to serving on the boards of their community hospitals do so with no personal profits motivation and indeed often at a significant personal sacrifice. These trustees object to the notion that their names may be raised in an "investigation" of transactions between a hospital and its officers and trustees merely because of their membership on the hospital board and where there has been no suggestion of wrongdoing. The proposed Section would make service on a hospital board itself a cause of suspicion and Government investigation.

Proposed Section 1132 presents a real danger of unwarranted Government intrusion into the legitimate management affairs of community hospitals and their Trustees, who are leaders of their communities. The provision does not limit the investigations HEW may make to instances in which fraud or abuse is suspected, or in which an investigation is required to determine reasonable cost. Under the terms of the language, investigations could be launched upon bureaucratic whim and without probable cause. The mere launching of such an investigation and the attendant publicity could injure trustees' reputations—even if they were entirely innocent of any wrongdoing. It could subject them without cause to suspicion by the very members of the community they seek to serve.

I know of no trustee who would object to any request by the Secretary for information about related dealings where it is necessary to uncover fraud or abuse or to determine reasonable cost. However, trustees of nonprofit hospitals strongly object to any provision that implies wrongdoing in every related transaction and subjects them, their hospital, and their businesses to Government investigation without cause.

We fear, in short, that the passage of proposed Section 1132(a)(1)(D) would lead many able persons who would otherwise be inclined to serve or to continue to serve on hospital boards not to do so, creating a climate where hospitals fail to attract strong board leadership. We believe the language as written would raise legal questions in the minds of some who would otherwise serve on hospital boards. For one, it would deter staff physicians from serving on the board even though physician membership has been endorsed by the Joint Commission on Accreditation of Hospitals and CCH. The Government should be strengthening community hospital governing boards, not weakening them.

Proposed Section 1132(a)(1) has other weaknesses. It would permit HEW, without limitation to require disclosures about events that occurred years before, after memories that could amplify the written record have failed. It applies to all "business dealings"—an amorphous term that does not inform the trustees or their attorneys which events must be disclosed. Finally, the proposed Section misses an opportunity to address the question of transactions with officers and directors in an affirmative manner.

For all of the above reasons, we propose the amendatory language set forth below. This amendment would place a limit (three years) on a request for information about a transaction and thus not impose an unreasonable burden on hospitals with respect to the indeterminate past. It would also make the minutes of the governing board sufficient disclosure, thus introducing a reasonable and not burdensome standard of compliance into the bill. Our proposed amendment follows:

AMENDMENTS TO PROPOSED SECTION 1132(a)(1)(D)—PAGE 7

(1) Line 22. Delete "business dealings" and substitute therefore "transaction or contract."

(2) Line 23. Delete ", and" at the end of the line and add the following:

"that was entered into no longer than three years prior to the request. provided, that if the entity is exempt under Section 501(a) of the Internal Revenue Code pursuant to Section 501(a)(3) of such Code, furnishing those

portions of the minutes of the governing board that record (i) a policy of the board requiring consideration by the board of transactions or contracts between the provider and persons referred to in clause (C), and (ii) the resolution and the vote of the governing board specifically approving any such transaction or contract with respect to which such request shall be made shall constitute complete compliance with this paragraph."

Note.—Proposed section 1132(a)(1)(D) is set forth on page 8 of H.R. 12961, as passed by the Senate.

Mr. ROGERS. Thank you so much, and we appreciate your being here. And if you let us have some specific data we will look at it. Thank you for being present.

Thank you so much, and that concludes the hearings on this legislation.

The subcommittee stands adjourned.

[The following statements and letter were received for the record:]

STATEMENT OF BLUE CROSS ASSOCIATION

The Blue Cross Association welcomes this opportunity to comment on the Medicare and Medicaid anti-fraud provisions of HR 12961. It must be recognized that the vast majority of providers are honest and consciencious participants in these programs. Regrettably, legislation such as this is necessary to deal with the excesses of a small minority of Medicare and Medicaid providers of service.

Many of the provisions of this bill were contained in S. 3205, the proposed Medicare/Medicaid Administrative and Reimbursement Reform Act on which the Blue Cross Association testified before the Senate Finance Committee in detail on July 30, 1976. The following comments are focused on the specific legislation now before this Committee. The interested reader will find in our July 30th testimony useful background information and further discussion of issues related to matters now before the Committee.

CENTRAL FRAUD AND ABUSE UNIT

To evaluate the extent of the problem of fraud and abuse and to take corrective measures, an intensive effort is needed. We do believe, however, that the vast majority of providers are honest, and that fraud is probably of much less magnitude than abuse, which largely stems from provider misinterperations of law and regulations, lack of appropriate incentives or regulatory gaps.

An Office of Central Fraud and Abuse Control would be valuable if other departments in HEW did not continue their separate inspections of fraud and abuse. Although some degree of duplication in this regard might be necessary and valuable, there is the potential that this legislation would merely add another inspection level rather than producing the needed coordination.

We note that existing HEW and Congressional units such as the HEW Audit Agency, the Office of Investigations and the General Accounting Office could—and do—perform all or part of the proposed functions. As a result, we wonder whether the objective of this section could not be accomplished through expansion of existing investigatory bodies, by realigning priorities and by giving existing agencies more authority and accountability.

PROHIBITION AGAINST ASSIGNMENT OF FEES BY PHYSICIANS

We support this provision. It should substantially reduce the opportunity for fraud and abuse that have resulted from the use of power of attorney agreements concerning assignment.

DISCLOSURE OF OWNERSHIP AND FINANCIAL INFORMATION

If applied on a broad scale, the reporting detail proposed in this section would be enormous. We agree that the government should have access to records and information which describe financial interests, transactions, etc., which affect government payments for services. But our concern is with the non-specific nature of the provision.

To protect related organizations against unwarranted and excessive requests for disclosure of such information, it would appear appropriate to limit to the following the circumstances under which the requests could be made:

1. Suspected fraud or abuse.
2. Prudent buyer misapplication (excessive cost or conflict of interest).
3. Related organization application.

We suggest substitution for the proposed Section 1132(a)(1)(E) the following: "(E)(i) a statement with respect to the costs and charges of related organizations (as that term is employed for purposes of Title 18) included in its cost report (ii) a statement, from any related organization identified in (i) above, with respect to the relationship of such costs and charges to the total costs and charges of the related organization."

The suggested change would give legislative authority for the reporting of information currently required for proper payment under the existing principles of reimbursement.

Reporting 5 percent of ownership and total reporting of security interest—particularly when both direct and indirect relationships are considered—appears to be excessive. It is not likely that such minor levels of interest would be pertinent to any of the three situations noted before. We suggest that a 10 percent interest would be adequate.

Regarding "consolidated" and "certified" cost reports, the provision would cause confusion without definition of "consolidated." A report consolidating two or more organizations could result in a great deal of information unrelated to provision of health care services by the provider. That could greatly increase the cost of auditing. The term "certified" is also undefined. If it means certification by certified or independent public accountants, this provision would greatly increase provider costs.

This section introduces a new term—"shared health facility"—into the Social Security Act. We are concerned that the present definition is too complex. In addition, "shared health facility" is a term in current usage and includes shared hospital laundries, etc. Since the basic intent of this section of the bill is to require disclosure of certain information by "Medicaid mills," we suggest that a more appropriate term be used and that the definition in the bill itself be more precise.

We support Section 1132(b) dealing with pharmacies, laboratories and suppliers of durable medical equipment as a necessary tool in detecting fraud and abuse. However, we urge that the administration of such a provision be reasonable and focus on high volume operations. An additional category of suppliers not covered under this or any other similar provision is free-standing renal dialysis treatment centers. Since Medicare and Medicaid pay for almost 100 percent of renal services, and the free-standing faciilties are a significant part of the volume, such a provision would be an appropriate safeguard.

PENALTY FOR DEFRAUDING MEDICARE AND MEDICAID

The proposal to make Medicare fraud a felony is desirable, although it is not necessary. There is a general provision in the U.S. Criminal Code (18 U.S.C. Section 1001) which makes it a felony to knowingly conceal or cover up a material fact or make a false statement in connection with any matter within the jurisdiction of a department or agency of the United States. In the decision of the U.S. Court of Appeals of the Fifth Circuit, involving United States versus Oakley G. Smith, there is precedent for felony, prosecutions of Medicare fraud.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

The proposed legislation would give to Professional Standards review organizations (PSROs) the added authority to abstract as well as to examine the records of any practitioner or health care provider. This would cover private physicians' as well as "Medicaid mills." While this provision clearly expands the possible role of PSROs in detecting and documenting possible fraud, it also opens up the possibility of PSROs creating ambulatory care data systems. This would be an extremely expensive duplication of current claims systems.

By including ambulatory care review as a priority in this bill, the proposed legislation would open up the Medicare Trust Fund for paying for all hospital ambulatory care review. "Medicaid mills," which are the target of this anti-fraud bill, are generally not hospital outpatient departments. If not limited and

focused more appropriately, this would be a very expensive provision because of the volume of services to be reviewed.

Finally, the proposed legislation provides that where a PSRO is found competent and is delegated review responsibility by the Secretary, its determinations of medical necessity, quality and appropriateness shall constitute the conclusive determination for purposes of payment. The Intermediary is not to conduct reviews of services with respect to those issues for purposes of payment. This provision affirms current practice. Because the areas where the PSRO has authority to make final determinations are not specified but only referenced in the bill itself, there may be some confusion as to the extent of PSRO authority. We feel, however, that under the provisions, the Intermediary would retain responsibility for claims review to determine eligibility, technical coverage issues, and reasonable and allowable costs and to monitor as required by the Secretary.

Statement of the American Hospital Association

Mr. Chairman and members of the Subcommittee, the American Hospital Association which represents some 7,000 hospitals and other health care institutions and more than 21,000 personal members is pleased to submit the following views and recommendations on H.R. 15536, a bill to strengthen the capability of the government to detect, prosecute and punish fraudulent activities in connection with Medicare and Medicaid progrems.

We agree with the statement made by Sen. Herman Talmadge when he introduced the legislation in the Senate that "the large majority of health care providers and institutions are doing an honest professional job" in seeking to provide medically necessary care of high quality to beneficiaries of government health care programs. Also, we agree that effective programs for detecting fraud and abuse in the Medicare and Medicaid programs are needed, together with efficient administration and enforcement of the law.

First, let me assure you that our Association fully supports the purposes of this legislation. The House of Delegates of the American Hospital Association, which is now meeting in Dallas, Tex., yesterday approved the following resolution:

"Whereas the total funds available for health care programs are limited, and should be used only to meet the legitimate needs of those covered by the programs; and

"Whereas the American Hospital Association and its member institutions have a vital interest on behalf of the public in helping to assure that no funds be spent for unneeded services or in fraudulent practices; therefore be it

"*Resolved*, That the House of Delegates of the American Hospital Association pledges its continued support for and cooperation with the federal government in a strengthened program to eliminate fraudulent practices in the Medicare and Medicaid programs, so that all funds that are appropriated for health care of the poor, elderly and disabled achieve their maximum potential."

Our careful study and analysis of H.R. 15536, as introduced, prompts us to place before your Subcommittee the following concerns and recommendations with regard to certain provisions of the bill.

SECTION 4

Section 4(c) of the bill defines for purposes of the Social Security Act the term "shared health facility" to which certain reporting and penalty requirements would be applicable. The principal elements of the definition include:

Health practitioners practicing their profession at a common physical location, or sharing common waiting areas, examining rooms, treatment rooms or other space, or the services of supporting staff or equipment, and,

Organized in a manner that places control over the management or supervision of substantial aspects of the arrangement or operation for delivery of health services in a person or persons other than employees of the practitioners.

A proviso is included in the definition to exclude from the term "shared health facility," providers of services as defined in Section 1861(u) of the Social Security Act (this includes hospitals), and health maintenance organizations as defined in Section 1876 of the Act.

Senate Report 94–1240 on H.R. 12961, which was passed by the Senate on Monday, in discussing the section of that bill which is comparable to Section 4 of H.R. 15536 states:

"It is not intended that the term 'share health facility' include hospital shared services organizations such as those meeting the requirements of Section 501(e) of the Internal Revenue Code, other arrangements whereby a group of hospitals acting together provide services to the members of the group, nor to one tax-exempt nonprofit hospital providing services to another such tax-exempt nonprofit hospital."

Recommendation.—The AHA urges that language similar to the above be included in Section 4 of H.R. 15536.

However, a widely expressed and greater concern on the part of hospitals and hospital shared services organizations is the choice and use of the term "shared health facility" in the bill for unregulated and poorly equipped "Medicaid mills" disclosed in recent investigations as receiving disproportionate amounts of program payments while engaging in fraudulent practices. This use of the term "shared health facility" tends to cast negative connotations on all hospital shared services organizations and hospitals, which we feel sure the sponsors of the legislation do not intend.

For years the AHA has encouraged the hospital field to engage in cooperative service arrangements as a cost savings activity. Such arrangements have been recognized as desirable by the Congress, which in 1969 enacted Section 501(e) of the Internal Revenue Code to permit hospital shared services organizations to operate on a tax-free basis. Further, the Tax Reform Act that Congress has just sent to the President, H.R. 10612, adds "clinical services" to the list of services that Section 501(e) organizations may provide their members. In addition, the National Health Planning and Resources Development Act which became law less than two years ago, Public Law 93–641, establishes as a priority national health goal, "The development of multi-institutional arrangements for the sharing of support services necessary to all health institutions."

Recommendation.—The AHA recommends that the term "shared health facility" be replaced by the term "shared health office."

SECTION 6

In Section 6 of the bill, which contains amendments related to Professional Standards Review Organizations, the phrases "(whether conditional or otherwise)" and "(whether conditionally or unconditionally designated)" are used. We believe the correct terminology in both instances is "(whether unconditionally designated or operational)."

Recommendation.—The AHA recommends the above suggested change in terminology be made in Section 6 of H.R. 15536.

Also, Section 6 of the bill as introduced provides that determinations of Professional Standards Review Organizations with respect to certain services furnished to beneficiaries of the Medicare program "shall constitute the conclusive determination on these issues for purposes of payment under this Act." This appears to deny providers the appeal rights they have been given in other sections of the Social Security Act. We do not believe this is intended by the drafters of the bill.

Recommendation.—The AHA recommends that this section be redrafted to ensure that the determinations of Professional Standards Review Organizations referred to in the section are subject to appeal by providers, as authorized in the Social Security Act.

Mr. Chairman, we very much appreciate this opportunity to make the above recommendations. We will greatly appreciate you and your Subcommittee's favorable consideration of them, for we believe they will improve the legislation.

Statement of the American Dental Association

We are pleased to have this opportunity to present the views of the American Dental Association concerning efforts by Congress to improve mechanisms for identifying and eliminating fraud and abuse under the Social Security Act health care programs. The American Dental Association strongly endorses those efforts and offers the cooperation of the dental profession in accomplishing this task. At the same time, we must reassert to the Subcommittee that the overall number of health care practitioners who are involved in fraud or abuse of these programs is very small. The vast majority of dentists and other health professionals who provide care under these programs is doing so honestly and

in a manner to provide the best care possible for program beneficiaries. Any reservations which we have with particular provisions of the bills before you are based on concerns that they may unnecessarily and unintentionally hinder the ability of this majority of practitioners to render care in a manner which is satisfactory to the patient and to the practitioner.

OFFICE OF CENTRAL FRAUD AND ABUSE CONTROL, INSPECTER GENERAL

H.R. 15536, the Medicare-Medicaid Anti-Fraud Act proposes the establishment within the Department of HEW of an Office of Central Fraud and Abuse Control. This office would be responsible for policy activities concerning federal efforts relating to fraud and abuse, for initiating and conducting investigations with respect to fraud or abuse, and for assisting state agencies in the establishment and operation of state antifraud and abuse activities. H.R. 15390 would create an independent Office of Inspector General within the Department to conduct and supervise audits and investigations relating to programs and operations of the Department, to provide leadership and coordination designed to promote economy and efficiency, to prevent and detect fraud and abuse in federal health care programs, and to keep the Secretary and Congress informed about problems and deficiencies relating to the administration of these programs.

As you are aware, the Department of HEW recently has significantly expanded its investigative abilities with regards to fraud and abuse under the Social Security Act health care programs. We commend the Department for these activities and believe that they will have a significant impact on the identification and detection of fraud and abuse. At the same time, we feel that administrative improvements such as those authorized in these two bills would give a greater impetus to these fraud and abuse control efforts.

We believe that the establishment of an Office of Central Fraud and Abuse Control could give added organizational strength and visibility to these efforts. The same would be true with the establishment of an Office of Inspector General. Although the independent nature of such an Office as authorized in H.R. 15390 could help to assure full and independent pursuit of all aspects of fraud and abuse or auditing problems, we are concerned that this independence from the health care delivery functions of the Department could lead to the potential development by the Inspector General of activities which might hinder the ability of health care practitioners to provide services under these programs or simply alienate these practitioners from the programs. In summary, we are in strong support of the purposes outlined by both of these approaches; however, we do have some concerns as expressed above. We also suggest that only one of the mechanisms proposed be used in order to prevent an overlap or duplication of authorities.

PROHIBITION AGAINST ASSIGNMENT

Section 3 of H.R. 15536 contains provisions prohibiting practitioners from assigning their claims for payment under Social Security Act health care programs except where the fee paid the individual collecting the claim is not based on the amount of billings or payments due.

We do not believe that this assignment, or so-called factoring process, is prevalent in dentistry. However, it is our understanding that one reason for the use of this process by health care practitioners is that it allows for an increased cash flow within the individual's office. We could suggest that improved administrative mechanisms under these health care programs to provide payment to the practitioner more quickly would eliminate a great part of the incentive for the use of this assignment process. At the same time, since apparently there has been some abuse in this area, we are in support of the basic intent of the provisions of this bill regarding limitations on the right to assign claims. We note that the Department of HEW has already accomplished a good part of this goal through regulations. We would suggest that the language of the bill be reviewed in order to assure that the bill does not prohibit legitimate abuse-free business practices by health care practitioners.

DISCLOSURE OF OWNERSHIP

Provisions in the bill which establish requirements for disclosure of ownership by providers or suppliers of items or services under the Medicare-Medicaid and Maternal and Child Health programs apparently have been designed to relate to entities such as shared health facilities. However, in their present

form, these provisions are very broad in scope and could be interpreted to apply to individual practitioners in group practice situations. We do not think that it is intended that this extensive information be required of individuals and would recommend that clarfications be made in the nature of entities to be covered.

SHARED HEALTH FACILITY

In an effort to establish greater regulation of so-called medicaid mills, the bill has included within its definition of facilities for which the entensive ownership and other information must be provided an entity to be known as a shared health facility. We realize the great difficulty in establishing a definition for such an entity. However, we believe that the present definition in the bill which relates to the actual structure of the entity and not to the practices of the entity is inadequate for purposes of identifying medicaid mills. This is an area where there has been shown to be clear cut fraud and abuse of federal programs, particularly the medicaid program. At the same time, we are concerned that there will be facilities which will fall under the category of shared health facility but which will not present the remotest chance of fraud and abuse. It is with regard to such entities that we are concerned with the provisions of this bill. This again could be a case where compliance with the extensive reporting requirements of the bill would hinder or alienate the individuals in such entities and cause them to decline to provide services under these programs. In addition, we do not believe that the definition will guarantee that all medicaid mills will be required to comply with the requirements of the bill. Variations in the structural set up of an entity would seem to enable the entity to evade the reporting requirements.

Unfortunately, in spite of these potential difficulties in the definition of a shared health facility, we are not able to recommend a satisfactory alternative definition. However, we believe that fraud and abuse efforts must be directed primarily through the investigative mechanisms and not through imposing overly inclusive reporting or other similar requirements on providers under these programs. Although the reporting requirements may assist in identifying potential sources of fraud or abuse to a limited extent, we believe that the increased investigative authorities contained in the two bills before you also would identify these possible fraud and abuse activities. Therefore, unless a tightened definition can be provided for a medicaid mill, perhaps it would be better to eliminate this entire approach to the fraud and abuse problem.

PENALTIES FOR FRAUD

H.R. 15536 would establish that fraud in the medicare and medicaid programs would become a felony rather than a misdemeanor, and that penalties under these programs would be substantially increased, both in terms of fines and in terms of potential length of imprisonment. We believe that correction of the fraud and abuse problems under these programs can be significantly assisted through the identification and punishment of individuals who engage in such practices. We support the provisions of the bill to increase penalties for fraud and abuse as a means to deter such activities.

AMENDMENTS TO THE PSRO LAW

In attempting to give priority to the review of ambulatory services provided by shared health facilities, the bill gives authority to the Secretary to allow PSROs to assume review responsibility with respect to specified types of health care services or specified providers or practitioners of such services.

Although we can appreciate the desirability of obtaining PSRO review of so-called medicaid mill services, we are concerned that the language of the bill could lead to a selective review process where certain types of providers or services are reviewed while other providers are not subject to such review. We believe that the bill should be consistent in indicating that priority is to be for review of shared health facility ambulatory services and that the Secretary would be able to specifically provide that PSROs could review such services.

In addition, the bill would allow PSRO review to be the conclusive review for many purposes of the Department. This means that the PSRO would then supersede the authority of various other review mechanisms. We believe that as long as PSROs are competent to assume this authority, this consolidation will be beneficial. We would recommend, however, that the authority for this conclusive re-

view be such that all similar review activities by other entities, including program review teams, be superseded by the PSRO.

Finally, the bill requires that PSROs provide data and information to the responsible state and federal agencies to assist them in identifying or investigating suspected cases or patterns of fraud or abuse. As you know, the PSRO program is essentially a peer review program designed to utilize educational techniques to assure high quality of services and to assure that services which are provided are necessary. We believe that the nature of such activities requires full opportunity for freedom of discussion and debate among PSRO members and with members of the various professions being reviewed. We believe it would be a mistake to add responsibilities to PSROs which would transform them into investigatory entities. We believe that such a change would seriously distort the original statutory purpose of PSROs and damage the ability of PSROs to carry out their primary functions. We think it is clear that full and free discussion of practice techniques of various individuals will be seriously hampered if the results of these discussions and the information obtained from them is to be turned over to an investigatory unit. We would urge that such a requirement not be included in the language of any final legislation.

In summary, the American Dental Association commends the members and committees of Congress who are developing workable techniques to detect and eliminate fraud and abuse under federal health care programs. We are in strong support of these efforts and with the basic principles outlined in these bills. However, we recommend that certain modifications be made in order to assure the continued participation of the vast majority of practitioners who are providing quality services honestly for participants in these programs. We also again offer our services in the continued development of this legislation.

National Association of Manufacturers,
Washington, D.C., September 23, 1976.

Hon. Paul G. Rogers,
Chairman, Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, 2125 Rayburn House Office Building, Washington, D.C.

Dear Chairman Rogers: The National Association of Manufacturers is extremely concerned about the problem of escalating health care costs. This is an issue of such complexity that there simply is no single solution. Therefore, our approach has become one of trying to identify specific areas within the broad cost problem and then offering recommendations on these specifics.

In our statement this past summer on health care costs before the Council on Wage and Price Stability, we stated that we would like to move away from quoting "percent of Gross National Product" spent on health as an indicator of the seriousness of the problem. The fact that in fiscal year 1975 we spent 8.3 percent of GNP on health really doesn't tell us much. The point is we really don't know how much of our resources we should be spending on health. Maybe 8.3 percent is too much; maybe it's not enough.

The NAM believes that a better approach to discussing the cost problem is in terms of how much of that 8.3 percent is being used inefficiently and what part of that resource allocation is being wasted. We believe that the lack of adequate quality and cost controls in the Medicare and Medicaid programs contributes to the overall escalation of health care costs, and that too much of the money being funneled into these programs is being wasted.

Therefore, the NAM provides the following comments on the "Medicare and Medicaid Anti-Fraud Amendments," which were introduced as S. 3801 by Senator Herman Talmadge and which are now included in H.R. 12961.

1. In its July 30, 1976, testimony on S. 3205, "The Medicare/Medicaid Administration and Reimbursement Reform Act," the NAM commented that the establishment of an office of Central Fraud on Abuse Control would be highly beneficial, providing the cost of enforcement would not exceed the savings gained. We suggested at that time that, after the first three years of operation, the budget and staffing of this office be tied to a percentage of the recoveries achieved through that office. Since the establishment of a Central Office of Fraud and Abuse is contained in the current Anti-Fraud amendments, we would again make this recommendation. Furthermore, while we realize the time constraints involved in

speedy passage of H.R. 12961, we are concerned that the Office of Fraud and Abuse will possibly be an additional cumbersome layer of bureaucracy within HEW. Therefore, we recommend that, early in the next Congress, consideration be given to the provisions of S. 3205 designed to consolidate the administration of these programs in a "Health Care Financing Administration," under the direction of an Assistant Secretary for Health Care Financing.

2. The National Association of Manufacturers gives complete support to the provisions of H.R. 12961 dealing with the following: increased penalties for fraud under medicare and medicaid; disclosure of ownership and financial information by providers and suppliers to the Secretary of HEW and to the Comptroller General; prohibition of factoring and other types of claims assignment; and involvement of PSROs in the monitoring of "shared health care facilities."

The National Association of Manufacturers supports passage of these Anti-Fraud amendments in this Congress. Furthermore, we urge continued work in the next Congress on reform of the medicare and medicaid programs. We strongly believe that reasonable controls in these established programs are an absolute prerequisite to any new National Health Insurance legislation and we recommend that Congress place priority on reform of medicare and medicaid over any expansion of health care coverage to other segments of the population.

The NAM commends the Subcommittee for its conscientious attention to the problems of medicare/medicaid fraud, and we appreciate this opportunity to comment on behalf of our members.

Sincerely,

BRENDA G. BALLARD,
Director, Employee Benefits.

[Whereupon, at 4:40 p.m. the subcommittee was adjourned.]

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